Chapter – 1

INTRODUCTION

“God, grant me the serenity to accept the things I cannot change,

The courage to change the things I can,

And the wisdom to know the difference.”

-Reinhold Niebuhr (1872-1971)

Assessing the extent of drug abuse is difficult as it involves measuring the size of a hidden population (UNODCCP, 2001). The margin of error can be considerable and tend to multiply as the scale of estimation is raised. Detailed information from Asia is available from only a few countries. The available qualitative information only allows guesstimates. For many countries, trend data on abuse reflect 'perceptions' by the authorities. Thus, the data should be treated with caution and should not be taken at face value.

Population surveys based on national probability sampling, also called National Household Surveys (NHS), provide information on the proportion of lifetime and current users of each substance. NHS, however, does not provide the most comprehensive picture. It reflects the overall level of drug use and lists commonly abused substances among general population in the country as a whole. Data from NHS needs to be supplemented by information on "hard to reach" groups and marginalised populations. Thus, local studies, studies on special sub-groups viz. street addicts, women, prisoners, mentally ill persons, youth etc. need to be carried out.
The above data should be supplemented by data on persons seeking treatment. These would reflect the treatment demand and would sharpen the focus on issues regarding intervention. Thus the information should be collected using different research methodologies and different perspectives. Cross-checking, triangulation and multiple indicators would possibly provide the most accurate picture.

Thus, a comprehensive picture of a country can only be obtained through multiple data sources using multiple methodologies, as has been carried out in the current survey. Each element supplements another. United Nations Office for DRUG Control and Crime Prevention (UNODCCP, 2000) recommended that information gained from general population surveys should be supplemented by special studies utilising ethnographic methods.

The magnitude, development and dynamics of drug abuse at the national level have not been well researched in India. This deficiency of data is due to a lack of resources on the one hand, and the sheer size and diversity of the country on the other. This "National Survey on Extent, Pattern and Trends of Drug Abuse in India" (henceforth 'National Survey') attempts to minimise the potential error of any single technique and uses different methodologies to project the data for the country as a whole. While data on a region or a specific site is made available, the focus of the report is on the nation as a whole. Finally, the report presents both quantitative and qualitative information.

The results of this National Survey will, hopefully, provide a framework to planners and policy makers to examine the current infrastructure, the means of intervention and suggest modifications to deal with the problem of drug abuse. The
study also forms a national baseline for later assessments of drug abuse problems. This will help to pinpoint trends over the years.

**Drug**

The WHO (1966) has given more comprehensive definition – “Drug is any substance or product that is used or is intended to be used to modify or explore physiological system or pathological states for the benefit of the recipient.”

The term ‘drugs’ is being also used to mean addictive/abused/illicit substance. However, this restricted and derogatory usage is unfortunate degradation of a time honoured term and ‘drug’ should refer to a substance that has some therapeutic/diagnostic application.

“Drugs as they are commonly known can be defined as substances occurring naturally or produced synthetically in laboratories or factories and used people because they except to benefit from their use, whether through the experience of pleasure or avoidance of pain”.

**Pharmacology**

Pharmacology is the science of drugs in a broad sense, it deals with interaction of exogenously administered chemical molecules (drugs) with living systems.

Pharmacology as an experimental science was ushered by Rudolf Buchheim who founded the first institute of pharmacology in 1847 in Germany. In the later part of the 19th century, Oswald and Schmiedeberg are regarded as the father of pharmacology.
Religion and Drug

Many religions have expressed positions on what is acceptable to consume as a means of intoxication for spiritual, pleasure or medicinal purposes.

Much of Hindu belief and practice grew out of the use of Soma, a god, plant, and drink which is the focus of the Rigveda. The continued entheogenic use of drugs such as Cannabis is not uncommon among various Hindu sects. Cannabis is connected with the god Shiva who is said to have rested in the shade of the Cannabis plant on a particular hot day. In gratitude, Shiva gave the plant to mankind. Often, the drink Bhang is drunk in Shiva’s honours.

Prior to the arrival of Muslims into India, use of opium and other intoxicants were not frequently present among the people of the society.

Opium, a kind of drug was introduced in India by Muslim Traders in 9th century A.D. during Mogal period. The use of intoxicants increased to a large extent. The Muslim kings used to take drugs in the form of Hukka which contain Bhang.

Drug addiction is one of the causable factors of crime. It produces physical and mental deterioration. It reduces the addicts income consequently criminal tendencies are encouraged. The drug addiction is more prevalent among the lower class people. Now-a-days, the addiction is spreading to the professional college students and a few high income groups people. It is practiced by both the sex people.

SERENITY PRAYER

The Serenity prayer is the common name for a prayer authored by the American theologian, Reinhold Niebuhur (1892-1971). It has been adopted by Alcoholics Anonymous and other twelve-step programmes. The best-known form is:
USE BY ALCOHOLICS ANONYMOUS

The prayer became more widely known after being brought to the attention of Alcoholics Anonymous in 1941 by an early member. The co-founder, William Griffith Wilson, and the staff liked the prayer and had it printed out in modified form and handed around. It has been part of Alcoholics Anonymous ever since, and has also been used in other twelve-step programmes. Grapevine, The International Journal of Alcoholics Anonymous, identified Neibuhrs the author (January 1950, pp.6-7), and the AA web site continues to identify Neibuhr as the author.

RECOVERY USE

The serenity prayer was adapted for groups settings in the recovery networks, such as Alcoholics Anonymous (AA), as well as Narcotics Anonymous (NA). The original text for this adapted prayer was: “Father, give us courage to change what must be altered, serenity to accept what cannot be held, and the insight to know the one from the other”. A slightly different version of the prayer has been adopted by 12 Step Groups: “God grant us the serenity to accept the things we cannot change, the courage to change the things we can, and the wisdom to know the difference.

Anti – Drug Abuse Campaign 2013, International level in Singapore City, Singapore Government, organized.“International Day against Drug Abuse and Illicit Trafficking June 26th Important background information

1. What is the International Day against Drug Abuse and Illicit Trafficking? How did it come about?

In 1987, the United Nations General Assembly decided to observe 26 June as the ‘International Day against Drug Abuse and Illicit Trafficking’ as an expression of its determination to achieve the goal of an international society free of drug abuse.
In Singapore, the ‘International Day against Drug Abuse and Illicit Trafficking’ will be commemorated on 26 June this year. Information stickers and commemorative sticky notepad dispensers will be given out to members of the public on 22 June (2-5pm) and 13 July 2013 (10 am – 5 pm) respectively. The commemorative sticky notepad dispensers will also be given out to all students and schools are encouraged to read out a message by the Chairman of the National Council against Drug Abuse (NCADA) on 12 July.

2. What is the theme of this year’s ‘International Day against Drug Abuse and Illicit Trafficking’?

The theme is ‘Life Does Not Rewind. Say ‘No’ to Drugs’. Through this slogan, we intend to remind youths and adults not to make the mistake of experimenting with drugs.

3. What is this year’s commemorative item and what will the students be doing?

Sticky notepad dispensers accompanied with notepads will be this year’s commemorative items. Information on the International Drug-free Day will be incorporated in the commemorative items. We hope to create awareness amongst students and the public on the objectives of the Anti-Drug Abuse Day and the significance of the green and white Anti-Drug Abuse Ribbon, which symbolises health, vitality and strength.

This year, we will be inviting the public and schools to participate in an anti-drug exhibition at Bugis + level 2 Atrium on 21 and 22 June. Volunteers will be assisting with the distribution of commemorative items and 22 June and 13 July 2013.
On 26th June each year, Singapore joins the world in observing the ‘International Day against Drug Abuse and Illicit Trafficking’. This year, the theme for Anti-Drug Abuse Campaign is ‘Life Does Not Rewind. Say ‘No’ to Drugs’. Information on the International Drug-free Day are incorporated in the commemorative items. Through this activity, we hope to create awareness amongst students and the public on the objectives of the Anti-Drug Abuse Day and significance of the green and white Anti-Drug Abuse Ribbon which symbolizes health, vitality and strength.

**Classification of Drugs**

Drugs can be classified into three categories which create different sensations and produce different effects.

1. **Depressants**

Depressants slow down the general activity of central nervous system. Alcoholic beverages, sedatives, vallum, avil, cough syrups; opium; cannabis (Bhang, Charas, Ganja, Hashish), etc. are some of the depressants.

**Mode of use**: Sedative hypnotics are taken orally or can be injected, alcohol : orally.

**Effects**: Initial Euphoria, lowering of inhibitions, concentration and judgement impaired, lack of hand eye co-ordination, Depression, Gastro intestinal problem and liver cancer, Kidney problems.

2. **Stimulants**

The consumption of stimulants causes certain euphoria or a ‘rush’ increased ‘heart rate’ enhanced body movement etc. Coca leaf and cocaine powder, tobacco,
Amphetamine Type stimulants (ATS)/substance, cannabis (Bhang, charas, ganja, hashish) are some of the stimulants.

**Mode of Use:** Amphetamine – use orally, Cocaine – taken orally or snorted, Crack – orally and snorted.

**Effects:** Sense of super abundant energy, chronic sleep problem, High blood pressure, irregular heartbeat, mood swings, acts of violence, homicide and suicidal rates high.

3. **Hallucinogens**

Hallucinogens alter the state of consciousness and frequently produce disturbance in thoughts and perception. LSD (Lysergic Acid Dithylamide) (orally taken) PCP (phencyclidine) (smoked, snorted, injected) are some of the Hallucinogens.

**Volatile Solvents:** These are volatile hydrocarbons and petroleum derivatives. Petrol and glue, Paints and Varnishes, Nailpolish remover, Ether and Benzene.

**Mode of Use:** Inhalation by sniffing

**Effects:** Initial Euphoria, clouded thinking slurred speech and staggering gait, sudden death, psychosis permanent brain damage, kidney, liver and heart get damaged.

They are drugs that dramatically effect perception, emotion and mental process. They distort the perception and produce hallucinations.

**Types and mode of use:** Lysergic acid dithylamide (LSD) : orally Phencyclidine (PCP) : Smoked, snorted, injected
**Effects**: Mood alternations, sense of vision become acute distortion of the sense of direction, distance and time, flash backs become passive and show no interest in life.

**Drug**

“Any substance that is taken in for reasons other than to maintain the normal functioning of the body”

**Problem of Drug use**

Using the substance itself is not the problem but the effects of the substance on the body and mind both short and long term are causes for serious concern. Moreover, their use has the potential to harm both directly and indirectly.

**Firstly**: Their use has acute physical and psychological impacts on the human body and mind.

**Example**: shortly after use of alcohol or cannabis there is an impairment of motor skills, perception, and increase in reaction time affecting complex activities driving operating machinery. Thus, the casualties resulting from driving after drinking alcohol or smoking cannabis and other accidents, suicides and assaults should also be seen as effect of substance use.

**Secondly**: Substance use effect chronic illness like cirrhosis of liver originating from alcohol use and lung cancer often caused by smoking nicotine. In this case the mode of use further adds to the hazards e.g. in case of those using drugs through injection may be infected with HIV, Hepatitis B & C if sharing needles, syringes and other equipments or substances.

The **Third** and the **fourth** harmful effect are those related to adverse social consequences – both acute and chronic.
Acute social problems, such as a break in a relationship or an arrest, and chronic social problems, such as defaults in working life or in family roles.

**Facts about Substance Use and Abuse**

Substance use and abuse can lead to substance addiction. According to research conducted by the National Institute on Drug Abuse, the natural end result of continued “substance use and abuse in drug addiction .......... addiction is a brain disease that gradually changes the brain into an organ that requires the drug”. Most substance abuse happens as a curious choice made by individual who has no intention of using the drug often or of becoming an addict. However, once the euphoric and pleasant effects of the drug are experienced, the person desires to have the experience again. As the individual returns to the drug repeatedly, the brain becomes more addicted to the drug until the drug gradually becomes an addict, many negative consequences and relationships exist for the user directly and indirectly related to his or her substance use.

**Cost**

According to the National Institute of Drug Abuse (NIDA), the economic cost of substance abuse in the United States alone was estimated at a staggering $97.7 billion in the year 1992; researches and economists believe it has increased with every year since 1975. Substance abuse and addictive disease have huge consequences on health care, employment, the criminal justice system and on the lives of individuals who are personally affected by the problem.

**High Risk Behaviour**

Substance abusers engage in high risk sexual behaviour, according to NIDA. Lowered inhibitions related to substance use and abuse cause drug users to engage
in sexual behavior with people who they know less well and do so more often. According to research reported by the National Institute on Drug Abuse, intravenous drug use is either directly or indirectly related to 36 per cent of all AIDS cases in the United States. Substance abuse is also correlated to virtually all sexually transmitted diseases within the United States, according to NIDA.

Alcohol and drug use and abuse are believed to be the major cause of accidental death and disability due to violence, suicide, drowning and automobile accidents, according to health.com an on-line source dealing with teens who abuse alcohol and drugs. Teens and adults who use and abuse substances are more likely to engage in destructive and high-risk behaviours.

**Motivation**

Substance abusers are not always initially motivated by curiosity or a desire to feel euphoric. Many substance abusers begin using medications prescribed by their doctors in an effect to deal with physical pain or other treatable disease, without an understanding that people can become addicted to prescription drugs, even when they are under a doctor’s care. As is true of the curious substance abuser, people who use prescription drugs are also exposed to the positive sensations produced by the drug and may become emotionally and physically addicted to the medication prescribed by their doctors. Addiction can and responsible law-abiding citizens.

**Legal Drugs**

Some legal drugs are as addictive as illegal drugs and, in some cases, more difficult to stop abusing. Alcohol and nicotine are examples of legal drugs that have addictive potential. Caffeine is also a legal drug. That is often abused to a
destructive level of use. Some users of legal drugs feel that the drugs are more
difficult to stop using, because they are considered harmless or associated with the
users public, as well as private life. For example, no one could use cocaine or heroin
while standing behind their work place building with other co-workers, but
cigarettes are often smoked under those conditions. Alcohol is considered socially
acceptable by most Americans and is served at many social gatherings. Caffeine is
in many non-alcoholic beverages and foods.

Drugs of Abuse

Drugs commonly abused include central nervous system depressants,
stimulants, psychedelic drugs and steroids. Central nervous system depressants
include alcohol, most prescription drugs and street drugs such as heroin. They cause
slower movements, retarded motor skills and slurred speech when taken to excess.
Stimulant drugs cause extreme hyperactivity, then long periods of sleep and low
energy, as the user becomes physically exhausted from his or her use of the
stimulant drug. Psychedelic drugs include LSD-25, blotter acid and some drug
combinations, that include club drugs, such as ecstasy. These drugs create colorful
effects, some hallucinations and create delusions when taken. Steroid drugs are most
often used by athletes, who attempt to build muscle mass or excel at some sports
event. The drugs are banned by sports officials, but continue to be used by athletes
they are difficult to detect through present drug screen methods.

Why primary care physicians need to know about alcohol related problems

Alcohol related diseases affect about 10% of the world’s population each
year (World Development Report, 1993). Such problems present in many different
ways to practitioners of almost every branch of medicine. Long before the patient
with established alcohol dependence comes to the attention of the specialist in addiction medicine, he/she is very likely to have sought help for various medical and surgical problems.

Problem drinkers have more frequent health visits at hospitals and clinics due to alcohol related physical illnesses.

- 23.3% of in-patients (40% of all males; 7% of all females) in a large Bangalore General Hospital had associated with drinking problems. However, only 20% of all the problem drinkers were detected by the attending physicians (Savita Sri et al., 1987).

- In a survey in the rural sector, among patients admitted to a District General Hospital in Karnataka, 54% of the male patients and 16% of the female patients were alcohol users. 52% of the male users had problem drinking.

- Among the patients attending the general practitioners clinics at a Taluka Head Quarters, 50% of the male patients were using alcohol and 54% of these users had problem drinking.

**However, alcohol related problems often go unrecognized**

- Inspite of high prevalence rates of alcohol problems in their patients only 1.4% to 2.3% of such patients were asked about alcohol use by their doctors whereas none of the patients were advised to stop alcohol use. Although a large proportion of the patients were consulting for what appeared to be clearly alcohol related problems, the medical professionals attending to them, did not pick them up. The patients were treated symptomatically without attending to the root cause. This sets up a revolving door pattern of
repeated admissions and discharges, which are a heavy toll on the state’s resources.

- There patients, with medical problems arising from harmful alcohol use, continue to visit multiple primary care physicians and avail of hospital facilities for an average of 11 years before they seek treatment for the advanced condition of alcohol dependence at a de-addiction facility [Singh et al, 1999]. By this time the condition is more refractory to treatment, the patient has developed considerably more serious medical problems, and has contributed to considerable economic and industrial loss to the state, as well as severe and often irreparable harm to the family.

Heavy drinkers [people who drink heavily but do not yet qualify as being alcohol dependent] account for more medical, Social and economic problems than the chronic "alcoholics".

- In a study of the causes of suicide in Bangalore in 1999, it was observed that out of 2600 completed suicides, 14% of all males who completed suicide and 1% females, heavy alcohol use featured as a trigger or predisposing condition. 24% of all attempted suicides [1500 subjects attempted but did not complete] were similarly alcohol related [Gururaj& Isaac, 1999].

- A pilot study assessing causes of death in the community in Bangalore found that 9 out of 30 deaths [30%] had heavy alcohol use as a direct or indirect cause [Gururaj&Narasimhan, 1999].

- Similarly, heavy use of alcohol was associated with 30% of all strokes listed in the Stroke Registry at NIMHANS [Gururaj&Nagaraj, 1999]
Reasons for under recognition of alcohol related problems

- **Lack of education about alcohol abuse:** Only a very small portion of the undergraduate medical syllabus is devoted to this area, and limited only to the medical complications of alcoholism.

- **Negative attitudes about alcoholism:** Physicians in training often see late stage alcoholics, who often evoke feelings of aversion, hostility and helplessness. Some physicians tend to see alcoholics as bad or morally weak.

- **Pessimism about treatment:** There are many physicians who feel that alcoholism is not treatable. Part of the helplessness and pessimism occurs because of the experience with late stage problem drinkers where the treatment is not always successful. The physician must remember that detection and intervention of alcohol related problems offers the best results.

- **Discomfort with related social issues:** Since alcoholism involves not just medical issues, but significant psycho-social issues many physicians are uncomfortable dealing with it.

Rationale for Early intervention

Treatment for alcohol dependence after it has set in usually has a poor prognosis, with a recurrent, relapsing course. The focus therefore needs to shift towards interventions aimed at the early stage problem drinker. This is more promising in the long term and is also cost effective. The early stage problem drinker is most likely to present to the general hospital or the primary care physician. The patient is likely to present with any of a variety of disorders associated with alcohol abuse but may not often give a history of alcohol use. The
physician who is not aware may be likely to treat only the secondary disorder without attending to the alcohol problem which is likely to be the cause or perhaps a complicating factor.

+ selected by the family physician.

Several studies of early and brief physician interventions have demonstrated a reduction in alcohol consumption and improvement in alcohol-related problems among patients with drinking problems. A 40% reduction in alcohol consumption in nondependent problem drinkers has been demonstrated following physician advice to reduce drinking.

**Brief Intervention for alcohol related problems: an introduction**

In a brief intervention the clinician:

- Screens for harmful use of alcohol in the patient
- Provides links between patient's drinking and associated problems and advice about changing
- Assesses the patient's readiness to change
- Negotiates goals and strategies for change
- Plans follow-up monitoring.

Brief intervention involves clinician-patient contacts of 10 to 15 minutes -- the typical duration of a routine follow-up, and a limited number of sessions. At least one follow-up visit is usually recommended, but the number and frequency of sessions depends on the severity of the problem and the individual patient's response.
Goal of Brief Intervention

The broad goal of brief intervention is to get patients to reduce or stop alcohol or other drug consumption and thereby avoid or minimize associated problems. The specific goal varies depending on the patient's current status and previous treatment attempts. For a patient who does not realize there is a problem, the goal may be to get the individual to start thinking about the issue and come back for another visit.

A brief intervention could be for

- The alcohol or drug user who is at risk for problem development because of a hazardous consumption pattern but has not yet experienced harmful consequences (e.g. the college student or factory worker who is drinking heavily).

- Patients who recognize that some of their health or other problems are alcohol- or drug-related, and who are ready for and capable of change, the goal will be to reduce or eliminate substance use through specified steps.

- Patients with more severe problems. If initial attempts to change do not succeed, the goal of brief intervention is to convince a patient to accept a referral for more specialized assessment and treatment services.

To be able to carry out an effective brief intervention for alcohol related problems, the physician must be aware of the wide spectrum of problems related to alcohol abuse, the effects of alcohol on different systems, its interaction with prescribed drugs and the different stages of alcoholism and their recognition. These are dealt with in the next few chapters. With this knowledge, the physician can feel better equipped to follow the techniques of brief intervention which are discussed later.
ALCOHOL CONSUMPTION: VARIOUS CONSIDERATIONS

Blood alcohol level and behaviour

Less than 0.060 g% - may act normally but insight, concentration and discrimination skills are impaired. There may be false sense of increased confidence and a feeling well-being.

Between 0.080 g% and 0.200 g% - impairment becomes more obvious. Muscle control and speech are affected. Muscle reflexes are impaired causing prolonged reaction time to startling events.

Above 0.200 g%, clear symptoms of alcohol poisoning occur. The rate of breathing is decreased, cutting down on the body's oxygen intake. The vomit control center of the brain may be activated causing the person to vomit.

DRINKING PATTERNS

Social Drinking

Refers to drinking patterns that are acceptable in a given society.

In Western Societies it is acceptable to have a glass of wine at mealtimes. Within India, in certain parts, alcohol use is an acceptable part of festivities. In cultures where alcohol use is not a widely accepted social practice, as in many parts of India, users tend to harmful.

Patterns of Drinking

Drinking to intoxication, drinking ‘large amounts’ over a small period, behaving irresponsibly such as being violent or disinhibited after drinking.
**Moderate Drinking**

May be defined as drinking that does not generally cause problems, either for the drinker or for society. However there are clearly both benefits and risks associated with lower levels of drinking.

**Problem Drinking**

Drinking leading to physical, psychological or serious social problems

**STANDARD DRINKS**

- One Standard drink = 30 ml of spirits or 60 ml of wine or One mug / ½ bottle of beer

Quantity of drinking is best expressed in terms of standard drinks. Each standard drink is equal to about 10 grams of ethanol.

**CLASSIFICATION OF DRUGS**

Drugs can be classified into three categories which create different sensations and produce different effects.

The consumption of drugs alters the following:

- The way a person perceives the world around him (hears, sees, smells, etc.)
- Mood cognition (thought process)
- Behavior (the way the person behaves with others)
- Motor functions (the way the person walks, talks etc.,)

Three categories:

1. Depressants  
2. Stimulants  
3. Hallucinogens
I. Depressants

- Alcoholic Beverages
- Sedatives : Vallum, Avil, Cough Syrups
- Opium
- Cannabis : (Bhang, chars, Ganja, Hashish)

II. Stimulants

1. Coca Leaf and Cocaine powder
2. Tobacco
3. Amphetamine Type Stimulants (ATS) / Substance
4. Cannabis (Bhang, charas, Ganja, Hashish)

III. Hallucinogens

1. LSD
2. Cannabis (Bhang, Charas, Ganja, Hashish)
I. Depressants

Depressants slow down the general activity of central nervous system. For example a slowing down of reflexes or the inability to walk straight.

II. Stimulants

The consumption of stimulants causes certain euphoria or a ‘rush’, increased ‘heart rate’, enhanced body movements etc.

III. Hallucinogens

Hallucinogens alter the state of consciousness and frequently produce disturbances in thoughts and perceptions.

<table>
<thead>
<tr>
<th>Mode</th>
<th>Example</th>
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<tbody>
<tr>
<td>Drinking</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Chewing</td>
<td>Tobacco</td>
</tr>
<tr>
<td>Swallowing</td>
<td>Spasmoproxyvon</td>
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<tr>
<td>Chasing</td>
<td>Brown Sugar / Patta</td>
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<tr>
<td>Snorting</td>
<td>Cocaine</td>
</tr>
<tr>
<td>Injecting</td>
<td>Heroin, SP</td>
</tr>
<tr>
<td>Smoking</td>
<td>Heroin, Cocaine, Tobacco</td>
</tr>
</tbody>
</table>

Tobacco, solvents and certain pharmaceuticals are legal or licit drugs whereas opiates, cannabis, etc. are illegal or illicit drugs.
Differentiates between Licit and Illicit

Classification of Drugs

<table>
<thead>
<tr>
<th>Legal (Licit)</th>
<th>Illegal (Illicit)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicines (pharmaceuticals)</td>
<td>Opium</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Heroin</td>
</tr>
<tr>
<td>Alcohol</td>
<td>Cocaine</td>
</tr>
<tr>
<td>Caffeine/Tea</td>
<td>ATS</td>
</tr>
<tr>
<td>Marijuana</td>
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</tbody>
</table>

Terminology associated with drug use

When do we know that someone is ‘addicted’ to drugs?

What is dependence?

Use: The ingestion of drugs (alcohol etc.) without the experience of any negative consequences.

Example: If a student drank a beer at a party and his parents did not find out, we could say he used alcohol.

Misuse: when a person experiences negative consequence from the use of drugs (alcohol etc.) it is misuse.

Example: A 40 – year old man uses alcohol occasionally. His boss throws a party where the man drinks more than usual and on the way home he is arrested by police.

Abuse: ‘Abuse’ is a maladaptive pattern of use resulting in physical, social and legal harm. It implies continued use inspite of negative consequences.

Example: The same 40 year old man continues drinking alcohol after the incident.
**Dependence** : The drug user should be considered (diagnosed) to be a dependent user if three or more of the following six criteria are present for consistently over a one-year period.

1. **Tolerance**
   - Need for increasing the amount of substance consumed in order to achieve intoxication or the desired effect.
   - Markedly diminished effect with continued use of the same amount of substance.

2. **Withdrawal**
   - Set of symptoms experienced on stopping or reducing the amount of the substance after prolonged use.
   - Every class of substance (e.g. alcohol, opioids etc.) has its own unique set of withdrawal symptoms.

3. **Impaired control over drug use in term of its**
   - Starting, Stopping, Controlling the levels of use

4. **Pre-Occupation – a great deal of time is spent on**
   - Obtaining the drug, Using the drug, Recovering from its effects

5. **Continued use despite harm**

6. **Craving – a strong desire to use the substance**

   There are ‘stages’ in drug use, i.e. there is a progression of substance use in terms of graduation from less dependence – producing and more Socially acceptable substances to more dependence – producing, illicit and harmful forms of substances. It is understood that any individual rarely starts his drug use career with substances
like Heroin, most individuals usually begin by using substances like tobacco, alcohol or cannabis and then gradually begin the use of other substances.

The ‘Stages’ of drug use therefore are as follows

Some users start taking opioid injections directly, without an intervening period of brown sugar chasing. Additionally some times people are given prescriptions of opioid injections for health reasons (such as pain) by doctors. A few people thus start taking opioid injections legitimately as pain-killer medications, but gradually develop dependence on it.

A few of the symptoms of opioid withdrawal that range from mild/moderate to severe. The symptoms are listed in the given box:

<table>
<thead>
<tr>
<th>Mild – moderate symptoms</th>
<th>Severe symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>Severe anxiety</td>
</tr>
<tr>
<td>Restlessness</td>
<td>Restlessness</td>
</tr>
<tr>
<td>Yawning</td>
<td>Diarrohea (loose motions)</td>
</tr>
<tr>
<td>Nausea</td>
<td>Vomiting</td>
</tr>
<tr>
<td>Sweating</td>
<td>Piloerection (goose bumps)</td>
</tr>
<tr>
<td>Rhinorhea (running nose)</td>
<td>Muscular pain</td>
</tr>
<tr>
<td>Lacrimation (running eyes, tears)</td>
<td>Chills</td>
</tr>
<tr>
<td>Dilated pupils</td>
<td>Increased heart rate</td>
</tr>
<tr>
<td>Abdominial cramps</td>
<td>Increased blood pressure</td>
</tr>
<tr>
<td></td>
<td>Increased temperature</td>
</tr>
</tbody>
</table>
What are the harms related to drug use?

Different drugs have different effects on the health (physical and mental) of a person. These effects depend on:

- Health of the drug user
- Properties of the drug
- Mode of administration
- Dose
- Duration of use

Five drug related harms

**Drug Related Harms**

<table>
<thead>
<tr>
<th>Physical</th>
<th>Occupational / Financial</th>
<th>Familial / Social</th>
<th>Psychological</th>
<th>Legal</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Respiratory problems</td>
<td>- Absenteeism from work</td>
<td>- Marital</td>
<td>- Guilt /Shame</td>
<td>- Involvement in illegal activities</td>
</tr>
<tr>
<td>- Breathlessness</td>
<td>- Frequent change of job</td>
<td>Disharmony / Separation</td>
<td>- Lack of motivation</td>
<td>- Arrest</td>
</tr>
<tr>
<td>- Infections</td>
<td>- Job loss</td>
<td>- Divorce</td>
<td>- Depression</td>
<td>- Imprisonment under NDPS 1985 Act</td>
</tr>
<tr>
<td>local (abscess)</td>
<td>- Debits due to expenses</td>
<td>- Disowned By Family</td>
<td>- Anxiety</td>
<td></td>
</tr>
<tr>
<td>- (HIV, Hep-B, Hep-C)</td>
<td>incurred on drugs</td>
<td>- Homelessness</td>
<td>- Other mental disorders</td>
<td></td>
</tr>
<tr>
<td>- Poor nutrition weakness</td>
<td></td>
<td>- Loss Of Reputation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Weight loss</td>
<td></td>
<td>- Rejection By Community</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Overdose</td>
<td></td>
<td>- Stigma And Discrimination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Death</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Inter relationship between Harms

Do remember to communicate the following

- Harms are caused in various spheres of drug users, lives namely Physical, Social, Occupational and familial. These spheres are closely interrelated.

- Drugs can be classified into three main categories which create different sensations and produce different effects namely, Stimulants, hallucinogens and Depressants.

- Tobacco, solvents and certain pharmaceuticals are Legal or Licit drugs whereas opiates, cannabis etc. are illegal or illicit drugs.

- There are ‘Stages’ in drug use, i.e. there is a progression of substance use in terms of graduation from less dependence producing and more socially acceptable substance to more dependence producing, illicit and harmful forms substances.

- There is a certain network of inter-dependency of harms and it is necessary to understand these connections while working with a client.
# Understanding Drugs: Drug Matrix

<table>
<thead>
<tr>
<th>Name of the Drug</th>
<th>Effect of the Drug</th>
<th>Legal/Illlegal</th>
<th>How is it used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td>Depressant</td>
<td>Legal</td>
<td>Drinking</td>
</tr>
<tr>
<td>Opioids (Heroin)</td>
<td>Depressant</td>
<td>Illegal</td>
<td>- Swallowing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Injecting</td>
</tr>
<tr>
<td>Volatile solvents</td>
<td>Depressant</td>
<td>Legal</td>
<td>Smelling</td>
</tr>
<tr>
<td>Sedative – Hypnotics</td>
<td>Depressant</td>
<td>Legal</td>
<td>- Swallowing</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Drinking</td>
</tr>
<tr>
<td>Cannabis (Bhang, Charas, Ganja, Hashish)</td>
<td>- Depressant - Stimulant - Hallucinogen</td>
<td>Illegal</td>
<td>Smoking</td>
</tr>
<tr>
<td>Cocaine</td>
<td>Stimulant</td>
<td>Illegal</td>
<td>- Snorting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Injecting</td>
</tr>
<tr>
<td>Tobacco</td>
<td>Stimulant</td>
<td>Legal</td>
<td>- Smoking</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Chewing</td>
</tr>
<tr>
<td>Amphetamine Type Stimulants (ATS)</td>
<td>Stimulant</td>
<td>Illegal</td>
<td>- Smoking</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Injecting</td>
</tr>
<tr>
<td>LSD</td>
<td>Hallucinogen</td>
<td>Illegal</td>
<td>- Injecting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Swallowing</td>
</tr>
</tbody>
</table>
Consumption of Drugs

1. Cocaine, morphine, heroin up to 1 year or fine up to Rs.20,000/- or both

2. Other drugs – 6 months or fine up to Rs.10,000/- or both

3. Addicts volunteering for treatment enjoy immunity from prosecution.
Regular use: Cumulative Damage beyond certain levels

- No more than two unit drinks per day for men and no more than one drink per day for women, with never more than four drinks per occasion for men, three for women—and trying not to touch alcohol at least 3 days a week.

- These are prescribed levels in the west --- the level for Indians is likely to be much lower!

**IS ‘SAFE DRINKING’ POSSIBLE?**

There can be no universal ‘safe’ drinking limits. A given dose of alcohol may affect different people differently. It is not just the total alcohol consumed, but the manner in which it is consumed that may influence harm. (eg. One drink taken each day may have different consequences than seven drinks taken on a Saturday night). Thus called ‘safe’ limits of drinking which have been calculated based on the “average number of drinks per week,” in western population.

**The beginning Stages of Alcoholism**

Alcoholism can develop in many different ways. Some begin drinking to the point of intoxication from the start. This results in almost immediate problem in
health and relationships. Others suffer a progressive disease, beginning with social drinking. In the early stages, drinking helps to improve mood, calm down, celebrate, mourn, be sociable or to withdraw. As the disease progresses, the drinking is no longer restricted to such specific situations. The person does not need a specific reason to drink, and begins to drink every day or in a predictable pattern such as weekends.

Patients in the earlier stages of alcohol-related problems may have a few or suitable clinical findings, and the physician may not suspect a high consumption of alcohol. Certain medical complaints, such as headache, depression, chronic abdominal or epigastric pain, fatigue and memory loss, should alert the physician to consider the possibility of alcohol related problems.

The first signs of heavy drinking may be social problems. The compulsion to drink causes persons to neglect social responsibilities and relationships in favour of drinking. Intoxication may lead to accidents, occasional arrest or job loss. Recovering from drinking can decrease job performance or family involvement. Social problems that indicate alcohol use disorders include family conflict, separation or divorce, employment difficulties or job loss, arrests and motor vehicle accidents.

Medical consequences of alcohol abuse can begin in the early stages of Drinking (table -1). It is important to recognize these early consequences and intervene before the late consequences follow
## Consequences of Alcohol Abuse or Dependence

<table>
<thead>
<tr>
<th>System / Category</th>
<th>Consequences (Early &amp; Middle Stages)</th>
<th>Consequences (Late Stage)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lever disease</td>
<td>Elevated liver enzyme levels</td>
<td>Fatty liver, alcoholic hepatitis, cirrhosis</td>
</tr>
<tr>
<td>Pancreatic disease</td>
<td>-</td>
<td>Acute pancreatitis, chronic pancreatitis</td>
</tr>
<tr>
<td>Cardio vascular disease</td>
<td>Hypertension</td>
<td>Cardio myopathy arrhythmias, stroke</td>
</tr>
<tr>
<td>Neurologic disorders</td>
<td>Headaches, blackouts, peripheral neuropathy, memory problems</td>
<td>Alcohol withdrawal syndrome, seizures, Wernicke’s encephalopathy, dementia, cerebral atrophy, peripheral neuropathy, cognitive deficits, impaired motor functioning</td>
</tr>
<tr>
<td>Reproductive system disorders</td>
<td>Fetal alcohol effects, fetal alcohol syndrome</td>
<td>Sexual disfunction, amenorrhea, anovulation, early menopause, spontaneous abortion</td>
</tr>
<tr>
<td>Psychiatric comorbidities</td>
<td>Depression, anxiety, sleep disturbances</td>
<td>Affective disorders, anxiety disorders, antisocial personality</td>
</tr>
<tr>
<td>Legal problems</td>
<td>Traffic violations, driving while intoxicated, public intoxication, motor vehicle accidents, violent offenses</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>-------------------------------------------------------------------------------------------------</td>
<td>---</td>
</tr>
<tr>
<td>Employment problems</td>
<td>Poor punctuality, sick days, inability to concentrate, decreased efficiency, indiscipline</td>
<td>Accidents, injury, job loss, chronic unemployment</td>
</tr>
<tr>
<td>Family problems</td>
<td>Family conflict, erratic child discipline, neglect of responsibilities, social isolation</td>
<td>Divorce spouse abuse, child abuse or neglect, loss of child custody</td>
</tr>
<tr>
<td>Effects on children</td>
<td>Poor concentration, dullness and withdrawal, poor scholastic performance losing their ‘child likeness’</td>
<td>Learning disorders, behaviours problems, emotional disturbance</td>
</tr>
</tbody>
</table>

**MIDDLE STAGES:**

The middle stage of alcoholism is associated with a strong compulsion to drink. This often results in the person beginning to drink earlier in the day. He prefers alcohol related activities and friends who drink. The person needs to drink increasing amounts to get the desired effect (tolerance). There is increasing lack of control, drunkenness and blackouts.
Drinkers in this stage begin to be secretly ashamed and worried about lack of control. They may try to control their drinking or stop completely, but these attempts often fail. They may switch brands or kinds of alcohol and go from hard liquor to beer.

Eventually the alcoholic exhibits signs of denial, one of the chief psychological symptoms of Alcoholism. In the midst of the growing problems linked to alcohol consumption drinkers blame everything except alcohol for their plight. Unhappy relationships, financial difficulties, and work problems are all blamed for the need to drink. What the person fails to understand is that the heavy drinking is not the result of these problems but the cause.

Although drinkers claim they drink to relieve fatigue, anxiety, and depression, alcohol, in large amounts, worsen these feelings. Heavy drinking also brings out feelings of anger, self-loathing, and lack of self-esteem and may lead to violent anger outbursts aimed at the family and friends.

The drinker and his family may start making excuses for risk behavior are to friends, colleagues, bosses or subordinates. Such excuses and lies ‘enable’ the alcoholic to continue drinking and avoid consequences of his or her behavior. At this stage, physical symptoms that may be evident include frequent complaints of

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**Some common terms associated with early alcohol addiction**

- **Blackout**: a type of amnesia that allows functioning (such as making dinner or driving) but which blots out memory of the occasion later on.
- **Tolerance**: Needing progressively more alcohol to get the desired effect
- **Binge Drink**: Drinking more than five drinks in a day
stomach upset, nausea, vomiting, minor had tremors and other nonspecific physical and psychological symptoms.

3. Final Stages

<table>
<thead>
<tr>
<th>Alcohol dependence</th>
</tr>
</thead>
<tbody>
<tr>
<td>A pattern of alcohol use characterized by:</td>
</tr>
<tr>
<td>• Compulsion to use</td>
</tr>
<tr>
<td>• Loss of control (of use onset, termination, or level use)</td>
</tr>
<tr>
<td>• Withdrawal symptoms on use reduction on cessation</td>
</tr>
<tr>
<td>• Tolerance</td>
</tr>
<tr>
<td>• Neglect of alternative pleasures or interests</td>
</tr>
<tr>
<td>• Persistent use despite the knowledge of physical or psychological harm</td>
</tr>
</tbody>
</table>

Persons suffering late-stage alcoholism finally become preoccupied with alcohol to the exclusion of almost everything else. They drink despite the pleading of family and the advice of doctors. Although relationships with family and work may become completely served, nothing, not even severe health problems, is enough to deter drinking.

The late-stage alcoholic may suffer from anxiety, depression, guilt and remorse, all of which he may try to control by drinking more. Debts, legal problems, and homelessness may complicate the situation further. Late stage addiction is characterized severe withdrawal symptoms if alcohol is withheld (shakes, delirium tremens and convulsions), as well as a series of severe physical problems. These problems necessitate hospitalization and long-term treatment. However, treatment at this stage has a poorer outcome than early intervention.
Alcohol and cognition

Alcohol adversely affects the brain. When health professionals encounter patients who are having cognitive difficulties, such as impaired memory, or reasoning ability, alcohol use may be the cause of the problem. When treating patients who have abused alcohol; it may be of value to attempt to identify the level of any impairment and to modify the treatment accordingly.

Alcohol related cognitive deficits may be:

- A direct consequence of alcohol consumption
- Indirect, due to complications such as head injury, nutritional deficiencies hepatic encephalopathy.

Alcoholics in treatment present a different picture. Although most alcoholics entering treatment do not have decreased overall intelligence scores, approximately 45 to 70 per cent of these patients have specific deficits in problem solving, abstract thinking, concept shifting, psychomotor performance, and difficult memory tasks. Such deficits usually are not apparent without neuropsychological testing.

Serious organic cerebral impairment is a common complication is severe alcoholics, occurring in about 10 per cent of patients. Two main organic disorders have been described with sudden cessation of alcohol consumption. Alcohol amnestic disorder (memory disorder) and dementia associated with alcoholism. Recently however, it has been recognized that these two disorders are not mutually exclusive and that some features of each often coexists in the same patient.

Alcohol can cause toxicity to the brain directly. In addition, some alcoholics may exhibit impairment as an indirect result of alcohol abuse, e.g. they may have
experienced a head injury, they may be eating and suffering nutritional deficits (such as thiamine or niacin deficiency) or they may have cognitive impairments associated with liver disease.

**What are the indirect effects of Alcohol on the brain?**

*“Hepatic encephalopathy” or Portal-systemic encephalopathy”*

Long term alcohol consumption can also damage the brain through indirect effects. By damaging the liver (hepatitis), alcohol impairs the deactivation of many of the toxins that are found in the normal diet. Toxic compounds such as ammonia that would otherwise be deactivated by the liver are released into the blood stream. When they reach the brain, the high concentrations of ammonia and other chemicals cause gradual psychological changes and mental confusion. If this condition continues, the person will become co-ordinated, incontinent, and may develop tremors (characteristically flopping “bat-wing” tremors) and abnormal eye movements. Without treatment, the person will go into a coma, and die.

**Neuropsychiatric symptoms related to alcohol use**

<table>
<thead>
<tr>
<th>Complaints</th>
<th>Due to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tremors of the hand (sweating, disturbed sleep, headache, blackouts)</td>
<td>Withdrawal, Hypoglycemia</td>
</tr>
<tr>
<td>Fits</td>
<td>Stroke</td>
</tr>
<tr>
<td>Poor</td>
<td>Encephalopathy</td>
</tr>
<tr>
<td>Concentration</td>
<td>Depression</td>
</tr>
<tr>
<td>Confusion</td>
<td>Wernicke</td>
</tr>
<tr>
<td>--------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Anxiety</td>
<td>Korsakoff's</td>
</tr>
<tr>
<td>Depression</td>
<td>Syndrome</td>
</tr>
<tr>
<td>Memory Problems</td>
<td>Dementia</td>
</tr>
<tr>
<td>Burning feet or pains</td>
<td>Neuromyopathy</td>
</tr>
<tr>
<td>Needles</td>
<td>Alcohol</td>
</tr>
<tr>
<td>Altered</td>
<td>Overdose</td>
</tr>
<tr>
<td>Consciousness</td>
<td>Delirium</td>
</tr>
<tr>
<td>Hallucinations and</td>
<td>Sub-dural</td>
</tr>
<tr>
<td>Delusions</td>
<td>Haematoma</td>
</tr>
</tbody>
</table>

**Alcoholic polyneuropathy**

Alcoholics often do not eat properly. In addition, alcohol makes the digestive tract unable to absorb enough nutrients from a normal diet to maintain body functions. Nerve, muscle, and brain tissue are extremely sensitive to low levels of vitamins, nutrients and minerals such as thiamine, magnesium, potassium, and phosphorus. When nutrient levels drop, these tissues slowly deteriorate. Symptoms of this degeneration include numbness in parts of the fingers, toes, and buttocks. With early treatment these effects may be decreased. However, this disturbance may never be completely reversed since there is actual damage to nerve and brain tissue.
Alcohol withdrawal syndromes

a. Sample withdrawal syndrome

Occurs following abrupt cessation or significant reduction tongue or eyelids later followed by nausea/vomiting sweating, elevated BP; anxiety; depressed/irritable insomnia. Significant mortality if complicated by trauma.

<table>
<thead>
<tr>
<th>Symptoms of alcohol withdrawal</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Feeling jumpy or nervous, feeling shaky anxiety</td>
<td>Headache, general, pulsating sweating, especially the palms of the hands or the face</td>
</tr>
<tr>
<td>Irritability or easily excited</td>
<td>Nausea, vomiting, loss of appetite</td>
</tr>
<tr>
<td>Emotional volatility, rapid emotional changes</td>
<td>Insomnia, difficulty falling a sleep</td>
</tr>
<tr>
<td>Depression</td>
<td>Pale skin</td>
</tr>
<tr>
<td>Fatigue</td>
<td>mental status changes mood changes rapidly</td>
</tr>
<tr>
<td>difficulty thinking clearly palpitations(sensation of feeling the heart beat)</td>
<td>Decreased attention span excitement</td>
</tr>
<tr>
<td>Rest illness increased activity</td>
<td></td>
</tr>
</tbody>
</table>

b. Alcoholic hallucinosis

Present in 25% of withdrawals. These consist of paresis decreasing alcohol intake. They may even be initiated while the patient is continuing to drink. Auditory hallucinations predominate usually consist of voices – reproachful, threatening and
maligning; or unstructured hallucinations – low – hum, chant, buzz, ring, shots or clicks. These may continue intermittently and unceasingly for 6-10 days.

c. Alcohol related seizures

<table>
<thead>
<tr>
<th>Alcohol related seizures may occur due to</th>
</tr>
</thead>
<tbody>
<tr>
<td>Withdrawal</td>
</tr>
<tr>
<td>Intoxication</td>
</tr>
<tr>
<td>Hypoglycation</td>
</tr>
<tr>
<td>Subdural haematoma</td>
</tr>
<tr>
<td>Neuroinfection</td>
</tr>
<tr>
<td>Cortical lesions</td>
</tr>
<tr>
<td>Precipitation of epilepsy by reduction of seizure threshold by alcohol</td>
</tr>
</tbody>
</table>

Seizures may occur as a direct toxic effect of alcohol withdrawal. Alcohol withdrawal seizures a classically described as generalized tonic colonic seizures, mostly occurring within 6 – 48 hours of last drink, usually peaking at 12-24 hours. About 3% of patients may go on to develop status epilepticus and in about 30% seizures precede DTs. Typical withdrawal seizures may occur in clusters of 1-6. Focal seizures are atypical. However recent research suggests that many of the seizures that occur in alcoholics occur during intoxication or outside period of withdrawal. Therefore it is important to carefully assess the patient presenting with alcoholism seizures.

Seizures with focal onset, seizures outside the ‘withdrawal’ period, antecedent head trauma, seizures preceding alcohol we must be appropriately recognized and treated.
d. Delirium tremens

Delirium tremens – common features

- fear, agitation, irritability
- confusion, disorientation
- marked tremulousness
- hallucinations, visual hallucinations (snakes, bugs etc.)
- Sensory hyperacidity (highly sensitive to light, sound etc.)
- delirium (severe, acute loss of mental functions)
- decreased mental status
- stuporous, somnolent, lethargic
- deep sleep that persists for a day or longer
- usually occurs after acute symptoms.
- seizures: usually generalized tonic – clinic seizures

Most common in first 24-48 hours

Most common in people with previous alcohol withdrawal complications
- other features of alcohol withdrawal may also prevent

Delirium tremens

A complicated alcohol abstinence disorder involving sudden and severe mental changes (psychosis) or Neurologic changes [include seizures] caused by sudden stopping or marked reduction in the use of alcohol.

One in ten alcoholics in withdrawal may develop delirium tremens. It is characterized by fever, tachycardia, profuse sweating, dilated pupils, flushing,
nausea/vomiting, confusion, disorientation and altered sensorium, visual and auditory hallucination, disorganized thinking, agitation, delusions, tremors, sleeplessness. Additional symptoms that may occur include, fever, stomach pain and chest pain.

It peaks in 2-3 days; may appear after recovery from other withdrawal symptoms (hallucination and symptoms usually resolve in 3-5 days but may be fatal in 5%. Most cases are begin and short lived with varying severity between intervals of complete lucidity over several days to weeks.

**Causes, incidence and risk factors**

Risk includes an alcoholic binge period where alcohol use in heavy and intake of food is inadequate. It may also be triggered by head injury, infection, or illness in people with a history of heavy use of alcohol. It is most common in people who have a history of experiencing alcohol withdrawal state when alcohol is stopped, especially in those who have an alcohol, intake greater than 10 units per day for several months, and in those with a history of habitual alcohol use or alcoholism that has existed for more than 10 years.

Symptoms occur because of the toxic effects of alcohol on the brain and nervous system. They may be severe and progress rapidly. Complicated alcohol abstinence is a medical emergency.

**Sings and Tests**

An examination of the neuromuscular system may show increased startle reflex, rapid rhythmic muscle tremor, or other changes indicating alcohol withdrawal. Evidence of increased autonomic function such as profuse sweating
may be present. There may be symptoms of dehydration or malnutrition and signs indicating electrolyte disturbances. An eye inspection may show abnormalities of eye muscle movement such as lid lag. The heart rate may be rapid and there may be an irregular heartbeat. The blood pressure may be normal or low.

A serum toxicology screen is usually positive for alcohol. Serum chemistry may show electrolyte disturbances, especially decreased levels of potassium and magnesium. An ECG (Electrocardiogram) may show arrhythmias. An ECG (electrocardiogram) may be performed to rule out other causes of seizures.

Outcome

Complicated alcohol abstinence is serious and may be life threatening. Symptoms such as insomnia, fatigue, and emotional liability may persist for a year or more or become chronic. Complications include seizures, heart arrhythmias that may be life threatening, injury to self or others caused by confusion / delirium or injury from falls during seizures.

e. Wernicke –Korsakoff Syndrome (Alcohol related amnestic disorder)

A brain disorder involving loss of specific brain functions, due to thiamine deficiency. Wernicke – Korsakoff syndrome usually affects people between 40 and 80 years old.

Nutritional deficiency

Alcohol displaces food from diet/demand for B Vitamins (B1) increase to handle alcohol metabolism. Also chronic alcohol use leads to a decreased capacity to absorb thiamine and folate from the small intestine. Impaired pancreatic functions hamperfat digestion.
The syndrome is actually two disorders that may occur independently or together. Wernicke’s disease involves damage to multiple nerves in both the central nervous system (brain and spinal cord) and the peripheral nervous system (the rest of the body). It may also include symptoms caused by alcohol withdrawal. The cause is generally attributed to malnutrition, especially lack of vitamin B1 (thiamine), which commonly accompanies habitual alcohol use or alcoholism.

**Wernicke’s encephalopathy is characterized by**

1. Mental disturbance (confusion, apathy, drowsiness leading to stupor, coma;
2. Acute/sabacuteopthalmoplegia (nystagmus, lateral rectus and conjugate gaze palsy);
3. Gait ataxia

Korsakoff syndrome, or Korsakoff psychosis, involves impairment of memory and intellect/cognitive skills such as problem solving or learning, along with multiple symptoms of nerve damage. The most distinguishing symptom is confabulation (fabrication) where the person makes up detailed, believable stories about experiences or situations to cover the gaps in the memory. Korsakoff psychosis involves damage to areas of the brain.

Signs of Korakoff’s psychosis includes retrograde and anterograde amnesia (confabulation) and limited insight and apathy to persons/events.

**Mortality 20% in early stages, 17% in chronic stages**

Thiamine begins improvement in ocular movements in hours to days ---- complete recovery over several weeks. Recovery of ataxia takes longer, and is rarely complete.
Only 15% of WKS ---- apathy and confusion clears completely in 2 weeks and <20% completely regain anterograde and retrograde memories.

Expectations (Prognosis)

Without treatment, Wernicke-korsakoff syndrome progresses steadily to death. With treatment, symptoms such as in co-ordination and vision difficulties may be controlled, and progression of the disorder may be slowed or stopped.

Some of the symptoms, particularly the loss of memory and intellect/cognitive skills, may be permanent. There may be a need for custodial care if the loss of intellect/cognitive skills is severe. Other disorder related to the abuse of alcohol may also be present.

Complications

Include a permanent loss of memory and loss of cognitive / intellectual skills, injury caused by falls, difficulty with personal/social interaction, neuropathy and shortened lifespan.

Alcoholic Neuropathy

A disorder involving decreased nerve functioning because of damage that results from habitual use of alcohol.

Causes, incidence and risk factors

Alcohol neuropathy may be caused by the toxic effect of alcohol on nerve tissue. It is usually also associated with nutritional deficiencies and may be indistinguishable from nutritional related neuropathies such as beriberi. It can affect autonomic nerves (those that regulate internal body functions) and nerves that control movement and sensation. Habitual alcohol use, prolonged heavy use of
alcohol, or alcoholism that is present for 10 years or more indicate high risk for alcoholic neuropathy.

Alcoholic patients have a high incidence of peripheral nerve disorders, which are predominantly polyneuropathies, but may also be mononeuropathies due to pressure palsy.

Alcoholic polyneuropathy is generally thought to result from inadequate nutrition, and specifically from a deficiency of thiamine and other B vitamins.

Alcoholic polyneuropathy is a gradually progressive disorder associated with symptoms and signs that reflect the involvement of sensory, motor, and autonomic nerves. The clinical abnormalities are usually symmetric and pre-dominantly distal. Symptoms include numbness, paresthesia, burning dysesthesia, pain, weakness, muscle cramps, and gait ataxia. The most common neurologic sings are the loss of tendon reflexes, the defective perception of touch and vibration sensation, and weakness. Autonomic disturbances are less common, when present, they may be associated with increased mortality.

Neuromuscular examination may indicate nerve disfunction. Reflexes may be abnormal, and focal neurologic deficits localized nerve abnormalities be present. Neurologic deficits are usually symmetrical. Signs of autonomic disfunction may be present. Eye inspection may show decreased pupil response or other abnormality. Blood pressure may show orthostatic changes (a fall in blood pressure when the person rises to a standing position).

Lab test may be performed as indicated by the history, signs and symptoms to rule out other possible causes of neuropathy.
Complications include disability, discomfort or pain and chronic injury to extremities.

**Assessment for alcoholic neuropathy**

- Nutritional studies (for deficiencies of vitamins B1, B6, B12, pantothenic acid, biotin, folic-acid, niacin, vitamin A.
- Nerve conduction studies and EMG

In certain cases the following may be indicated

- Nerve biopsy
- Oesophagastroduodenoscopy
- Cystourethrogram

**Alcoholic Cerebellar Degeneration**

The principal finding is gait ataxia, which is sometimes accompanied by limb ataxia. Slurring of speech, finger nose in co-ordination, nystagmus are other features.

**Psychiatric illness**

Patients with depression, anxiety and psychotic disorders tend to use alcohol for relief of mood, anxiety or fear. Alcohol is actually a depressant of the central nervous system. It tends to worsen such disorders in the long run, and the affected person is left, not only with the original mental problem, but additional alcohol related problems as well.
**Depression**

Depression is commonly found among people who drink heavily. Depression may occur in drinkers due to several reasons:

- As a reaction to alcohol related physical, psychological and social problems.
- As an independent depressive disorders. Here the patient may self-medicate by drinking.
- As a transient phenomenon during alcohol withdrawal. This spontaneously remits in most cases. However it is important to recognize this as a possible trigger for relapse.

**Suicide**

Suicidal attempts and completed suicides occur much more commonly in heavy drinkers, and this is not always necessarily due to severe depression.

**Anxiety**

Studies indicate that approximately 10 to 30 per cent of Alcoholics have panic disorder, and about 20 per cent of persons with anxiety disorders abuse alcohol. Among alcoholics entering treatment, about two-thirds have symptoms that resemble anxiety disorders. Anxious patients may use alcohol or other drugs to self-medicate, despite the fact that such use may ultimately worsen their clinical condition.

**Phobic Disorders**

Persons with phobic disorder especially social phobia often use alcohol to decrease their anxiety. This group of patients is vulnerable to develop alcoholism.
Other drug abuse

The heaviest alcohol consumers are also the heaviest consumers of tobacco. Concurrent use of these drugs poses a significant public health problem. Smoking and excessive alcohol use are risk factors for cardiovascular and lung diseases and for some forms of cancer. The risk of cancer of the mouth, throat or esophagus for the smoking drinker are more than the sum of the risks posed by these drugs individually. Compared with the risk for non-smoking non-drinkers, the approximate relative risks for developing mouth and throat cancer are 7 times greater for those who use tobacco, 6 times greater for those who use alcohol, and 38 times greater for those who use both tobacco and alcohol. Persons liable to addiction to other drugs such as opioid, cannabis, tranquilisers, etc. are also likely to use alcohol along with these drugs.

Alcohol and Psycho-Social Problem

Alcohol destroys the home much before it destroys the liver

The psycho social problems with alcoholism are well known. Arguments, physical violence, social stigma for the family, financial difficulties, emotional problems in the spouse and children are well known. A history of alcohol use in the husband should be ascertained when a women presents with unexplained injuries, emotional disturbances, especially vague somatic symptoms, depression or attempted suicide. Parental alcoholism should be enquired about when children present with school refusal behavioural or emotional problems.
Alcohol and women

The size of the problem

In India, until recently, women were projected only as the victims of male alcoholism, or as powerful agents of community change, initiating mass movements against alcohol sales and consumption. However more recently alcohol use among women is an increase. Admission of women with alcohol related problems at NIMHANS has increased four to five fold over a decade.

The effect of alcohol on women

Many adverse effects of alcohol are common to men and women. In some cases, women may be at greater risk and there are some problems special to women. In contrast to men who are drinking, women:

- Have greater physical problems at lower levels of alcohol consumption compared to men.
- Report fewer social problems
- Attain higher blood levels with the same amount of alcohol
- Suffer greater liver damage including cirrhosis and hepatitis with a shorter period and a lower level of daily drinking compared to men.

In addition heavy alcohol use has been attributed as a cause of infertility. Moderate alcohol consumption may contribute to the risk of specific types of infertility.

Breast cancer

Many studies have found that alcohol is associated with arosen risk of breast cancer. While it has not yet been proved conclusively that alcohol directly causes
breast cancer, until the association can be explained in other ways, alcohol should be regarded as a predisposing factor.

**How does alcohol affect pregnancy**

Alcohol is directly toxic to the fetus and causes birth defects. Women who consume two or more drinks per week while pregnant have a higher risk of spontaneous abortion. Most spontaneous abortions occur during the second trimester. While one or two drinks during an entire pregnancy might not have any noticeable effect, the poisonous effects of many drink can add up, leading to a spontaneous abortion.

Drinking while pregnant also increases the risk of still birth, or the birth of a dead infant. Still births can occur after heavy drinking in the last three months of pregnancy. Drinking alcohol at this stage of pregnancy lessens the amount of oxygen delivered to the developing child. This leads to fetal death and thus, still birth.

**Does alcohol cause birth defects?**

Alcohol is known to cause birth defects. Alcohol decreases the amount of blood flow to the fetus from the mother, thus cutting down on nutrient and oxygen transfer. It also inhibits cell division and interferes with replication of RNA. The effects of drinking on fetal development are so widely recognized that the phrase “fetal alcohol syndrome” is used to describe these symptoms in children.

The severity and number of defects in Fetal Alcohol syndrome depends on the amount of alcohol consumed by the mother and the stage of pregnancy in which drinking occurs. Low infant birth weight is seen with as little as two drinks per day.
Full Fetal Alcohol Syndrome may be caused by four to five drinks per day. Alcohol consumption harms the fetus at all stages of the pregnancy. There is no safe time during pregnancy for women to drink alcohol.

Victimisation

Women may be particularly likely to be the victims of another person’s drinking. Alcohol is thought to be a risk factor in the victimisation of women and it is known that women are the victims in a large proportion of violent crime. Alcohol has also been linked to the incidence or sexual assault and rape with some studies estimating that more than 50 per cent of men convicted of these offences had been using alcohol prior to the attack. Equally, high proportions of victims of violence, including sexual assaults, are themselves under the influence of alcohol at the time of the offence.

ROLE OF MEDICAL TREATMENT FOR ALCOHOLISM / DRUG ADDICTION

Alcoholic clients may visit the casualty with repeated injuries, suicidal attempts, or accidents, and the orthopaedic dept. with repeated fractures. Similarly, they might visit chest clinic, diabetic clinic, neurology, cardiology, gastroenterology, dermatology, and psychiatry units.

What is alcoholism and who is an alcoholic?

Alcoholism was declared a disease by the WHO and American Psychiatric Association in the year 1956.
An alcoholic is one whose drinking causes continuing problems in any area of his life (physical health, family relationships, job, financial status, etc.) and despite this, he continues using it because he has developed physical and psychological dependence on it. That is, his body becomes so accustomed to the presence of alcohol over a period of time, that when he stops using it, he experiences withdrawal symptoms. These symptoms range from tremors, sleep disturbances and nervousness to convulsions, disorientation and hallucinations. He also constantly struggles with thoughts of how, when and where he can have the next drink. His entire thinking revolves only around alcohol. This condition is called psychological dependence. Out of the 10 who start off as social drinkers, 1-2 end up getting addicted to alcohol.

**Physiological effects of alcohol**

- Absorbed from the alimentary tract (especially stomach and small intestines)

- Alcohol needs no digestion; is absorbed directly into the blood stream

- Carried by blood to the brain and other organs

- 90% of the alcohol absorbed is metabolised in the liver

- 10% is excreted unchanged by the lungs and kidneys

- Oxidation of alcohol produces heat and energy

- Metabolites excreted through lungs and kidneys
### Diseases caused by alcoholism

<table>
<thead>
<tr>
<th>Category</th>
<th>Conditions</th>
</tr>
</thead>
</table>
| **Gastrointestinal** | Abdominal distention, pain, belching, and hematemesis  
Acute and chronic pancreatitis  
Alcoholic hepatitis leading to cirrhosis  
Cancer of the esophagus, liver, or pancreas  
Esophageal varicices, hemorrhoids, and ascites  
Gastritis, colitis, and enteritis  
Gastric or duodenal ulcers  
Gastrointestinal mal-absorption  
Swollen, enlarged fatty liver |
| **Cardiovascular**  | Alcoholic cardiomyopathy  
Increased systolic and pulse pressure  
Tissue damage, weakened heart muscle,  
and heart failure |
| **Genitourinary**   | Gynecomastia  
Prostate gland enlargement, leading to  
prostatitis and interference with urination  
Prostate cancer  
Sexual disfunction: decreased libido, impotency  
Infertility, decreased menstruation in females |
<table>
<thead>
<tr>
<th>Metabolic</th>
<th>Hypoglycemia, hyperlipidemia, hyperuricemia, Ketoacidosis, osteoporosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematologic</td>
<td>Abnormal red blood cells, white blood cells, and platelets Anemia and increased risk of infection Bleeding tendencies, increased bruising, and decreased clotting time Mineral and vitamin deficiencies (folate, iron, phosphate, thiamine)</td>
</tr>
<tr>
<td>Neurologic</td>
<td>Wernicke-Korsakoff syndrome, cerebellar degeneration Peripheral neuropathy, polyneuropathy Seizures, sleep disturbances Stroke (increased risk of hemorrhagic stroke)</td>
</tr>
<tr>
<td>Respiratory</td>
<td>Cancer of the oropharynx Chronic obstructive pulmonary disease, infection, and tuberculosis Respiratory depression causing decreased respiratory rate and cough reflex and increased susceptibility to infection and trauma</td>
</tr>
<tr>
<td>Trauma related</td>
<td>Burns, injuries from motor vehicle crashes and falls</td>
</tr>
</tbody>
</table>
How you can help

As we have already noted, healthcare providers encounter patients with alcohol related problems in all settings. However, very often, only the patient’s immediate concern is looked into (for instance, he receives treatment for pancreatitis, jaundice or for injuries from accidents) whereas his alcohol abuse is often not recognized, diagnosed or treated.

You as nurses have access to various departments and spend considerable amount of time with patients. You can assess and identify patients with alcohol-related problems so that the necessary and appropriate medical and nursing care is instituted in a timely manner. In other words, you are in key positions to identify alcoholic patients through close monitoring and careful observation, and to facilitate their access to appropriate and effective treatment through reporting your assessment to the physician.

Your assessment can be confirmed by collecting details from the patient. An ability to build a rapport with the patient can help in getting accurate information. He may not readily admit that he has a problem with alcohol. You have to be conscious of the fact that he may be experiencing fear of withdrawal, fear about the nature of treatment and fear about others coming to know about his problem. It is important that these inner barriers which prevent him from admitting his need for help are recognised and discussed with empathy.
i) Collecting medical history

- Collect history in the presence of a family member
- Speak in simple language and with clear, audible tone
- While collecting history, discuss with empathy, taking care not to appear judgmental, critical and accusatory
- Listen attentively and be alert while collecting information
- Demonstrate respect, care and concern when dealing with patients

Information to be collected

- Demographic details
- Years of abuse
- Average amount of alcohol consumed
- Last drink taken
- Withdrawal symptoms experienced earlier
- Problems related to health
- History of allergy to any drugs

ii) Detoxification

Detoxification is the process of medical management of withdrawal symptoms to ensure that it is handled in a safe and comfortable manner. The duration is 3-10 days depending on the intensity of withdrawal.
During detoxification

- Provide information to the physician about the drinking history
- Monitor the use of medication for symptomatic relief
- Handle emergencies and monitor patient regularly
- Offer support and reassurance

a. Withdrawal symptoms & their management

<table>
<thead>
<tr>
<th>Symptoms</th>
<th>Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tremors</td>
<td>B Complex/Multi vitamin with dextrose infusion if required</td>
</tr>
<tr>
<td>Insomnia</td>
<td>Chlordiazepoxide 100 to 200 mg. in divided doses and tapering it off gradually</td>
</tr>
<tr>
<td>Nausea and vomiting</td>
<td>Antacid, ulcer healing drugs and anti-emetic if required</td>
</tr>
<tr>
<td>Body ache and pain</td>
<td>Analgesics</td>
</tr>
<tr>
<td>Loss of appetite</td>
<td>Liver supplements</td>
</tr>
</tbody>
</table>
b. Emergency situations in the detoxification unit

b.1. Withdrawal seizures

(Occurs any time after stopping use of alcohol)

- Provide ventilation
- Turn the head to one side to prevent aspiration
- Prevent injuries to the patient
- Apply mouth gag to prevent tongue bite
- Clear the throat and apply suction if necessary
- Administer diazepam injection
- Continue with treatment of phenytoin sodium 100 mg. TDS
- Check vital signs for the next two hours
- Be supportive to the family
- Explain facts to patient on recovery

b.2. Delirium tremens - Signs and symptoms

- Agitation
- Disorientation
- Hallucination
- Confusion
- Sweating, palpitations
- Fluctuation of temperature, pulse, respiration &BP
Risk factors for delirium

- Old age
- Co-existing medical problem
- Prior history of delirium
- Severity of alcohol dependency
- Withdrawal symptoms are intense (excessive sweating, palpitation)
- Prior history of fits

Medical care

- Sedate with high dose of benzodiazepines orally or add injectable diazepam or lorazepam as per doctor's advice.
- If the patient remains agitated and violent neuroleptics can be added e.g. Haloperidol.
- Keep a record of intake, output and vital parameters
- Restrain the movement of patient if agitated or violent
- Apply side rails; maintain a calm environment, minimizing noise
- Sedate and carefully monitor the level of consciousness and his pupillary reaction
- Increase fluid intake with vitamins if necessary
- To avoid aspiration, no oral fluids to be given when the patient is under deep sedation
- Monitor vital signs hourly and inform the medical officer if there is any abnormality
- Attend to patient's personal hygiene
- Second hourly positioning to be done
- Back care to be attended to
- Reorientation can be done after the patient recovers from delirium

iii) Use of disulfiram deterrent therapy

Aversion or deterrent therapy involves a daily oral dose of disulfiram to prevent drinking.
- This drug interferes with alcohol metabolism and allows toxic levels of acetaldehyde to accumulate in the patient's blood, producing immediate unpleasant effects in the event he consumes alcohol
- Discovered in 1948 and has been in use since then in the treatment for alcoholism
- Dose 250 mg. per day

Alcohol disulfiram reaction

Mild to moderate reaction
- Throbbing headache
- Flushing of face
- Nausea, vomiting, abdominal pain, haematemesis
- Sweating
- Confusion, anxiety
- Vertigo, blurred vision
- Dyspnoea, hyper ventilation
- Hypotension
- Palpitations, tachycardia
- Redness of eyes
Severe reaction (rarely)

- Respiratory distress
- Crushing chest pain
- ECG changes of M.I.
- Hypotension shock
- Seizure
- Ventricular and atrial arrhythmias
- Death from cardiovascular collapse

Medical care

- Only supportive treatment with watchful expectancy is required.
- IV line to be started with GNS. Antihistaminic like chlorpheneramine maleate and steroids like dexamethasone can help getting relief from some of the symptoms.
- Antacids to reduce the gastric irritation.
- Ranitidine in case of blood vomiting.
- Vital signs to be monitored every 30 min till he stabilizes

iv) Dealing with alcohol users who are violent

- Sedation with benzodiazepines
- Avoid arguments and action which irritate the patient
- If violence continues, neuroleptics like haloperidol or chlorpromazine IV to be given with phenargan
- If the patient is sedated, vital signs to be recorded
- Restrict movement to ensure that he does not hurt himself or others
- Ensure safe environment
A model de-addiction centre for drug abusers in South India, Chennai

A few words about T.T.K. Hospital different Treatment Policy

T TRanganathan Clinical Research Foundation otherwise known as the TTK Hospital is a pioneer in the field of addiction treatment and rehabilitation over the past three decades. They major activities include:

**Treatment for alcoholism / drug addiction** – they offer a one month residential primary care programme with both medical and psychological therapy for the patients along with therapy for their families. Follow-up is maintained for a period of two years. A two month extended care facility is also available in After Care Centre. Out reach treatment camps are also regularly organised to treat the rural poor.

**Prevention education**

Workplace alcohol prevention and community based awareness programmes are a part of their on going efforts.

**Training** - Recognised as a Regional Resource and Training Centre (RRTC), they offer training for various groups at the Local, National and International levels. Training programmes are conducted for students of medicine, nursing, psychology, social work and counseling.

**Publications** - A number of manuals, books and pamphlets with authentic case studies, relevant to the cultural context, have been published for circulation.
THERAPEUTIC COMMUNICATION SKILLS

MAKE CLIENT FEEL CONFIDENT THAT YOU ARE ATTENDING WITH

A. NON-VERBAL SKILLS

SIT SQUARELY

OPEN STANCE

LEAN FORWARD

EYE CONTACT

RESPOND EMPATHETICALLY

Postures : We have discussed this in the above

Gestures : This should be minimal or else will distract client.

You could nod your head, smile, or even touch

Voice quality: The tone should match that of the client.

Energy level : Try to keep your speech moderate: not too high or animated, and not too low and depressive

B. VERBAL SKILLS [To facilitate the session]

➢ Use appropriate words to take session forward

[I see, must have been hard, is that right]

➢ As far as possible try to speak the language the client understands

[The dialect may be different, some words may be unfamiliar]
Reflect back and ensure you have the correct message

[This is necessary, especially when you are not too sure]

Avoid "why" question. They can be threatening

[Why did you do that? Why did you feel bad?]

How and What questions are more helpful

[How did you feel? What was going on in your mind?]

Try and put the question back to help the client

[What do you think you could have done?]

Give something positive - for the feel good factor.

[You are looking smart, you are very punctual]

TIPS FOR COUNSELLORS TO DEVELOP EFFECTIVE LISTENING SKILLS

TO BEGIN WITH

Let us examine what nature has designated for us.

We have been endowed with 2 ears.

The 2 ears are: 1 for meaning and 1 for feeling.

We have been endowed with 1 mouth.

So what nature is telling us is: -

Listen twice as much as you talk!

Counsellors who do not listen

have less information for client handling
ADDITIONAL TIPS

- Stop talking! If you are talking, you cannot listen.

- Make the client feel at ease. Allow the client to feel free to talk. We call this a permissive environment.

- Indicate to the client that you want to listen. Look and act interested. Listen to understand not oppose. Do not read etc.

- Remove all forms of distractions. Ensure that the door is shut, the phone is off the hook, nothing attention drawing on your table. Do not doodle, click pen, arrange papers etc.

- You must emphasize. Concentrate on what the client is saying and understand the client's point of view.

- Be absolutely patient. Allow the client plenty of time. Do not interrupt. Do not go to attend to some task.

- Must have your temper in control. An angry counsellor can make faulty deductions and conclusions.

- Avoid arguments and criticism. The client could become defensive and clam up or get angry and offensive.

- Use soothing sounds and monosyllables. Also ask relevant and non-threatening questions. It will show that you are listening. It will take the session further.

- The last again is STOP TALKING. This is the first and the last principle of listening skill. You just cannot do an effective listening job if you are talking! As simple as that!
ETHICS IN COUNSELLING

1. Counselling Case - not for curiosity or entertainment
2. Confidentiality - an absolute must
3. Concentration - throughout the session
4. Connection - ensure that it is there
5. Concern - without it forget dealing with people
6. Comprehension - be sure it is present
7. Conception - process includes comparisons, generalizations,
8. Catharsis - do not restrict, allow freedom, let her/him be
9. Capacity - think of your caseload
10. Common Sense - depend on this and get feeling for the right thing to do

BASIC COUNSELLING TECHNIQUES

Counselling techniques are the ways in which you take the counselling process through from intake to closure. It is something dynamic and will change as you gain experience. In essence they are the tools you use and develop into skills. We can put them under the following areas for convenience:

ATTENDING

In any counselling process you have to physically and psychologically attend to the person who comes to you as a client. Through verbal and non-verbal skills you have to communicate to the person that you are paying attention and are interested in what the client is saying and feeling. Every nuance of the client's movement has to be attended to, for you to make the right diagnosis and assessment to take it forward. We will learn more about this when we discuss communication skills.
LISTENING

There are many components in the listening technique, which enhances each session. I will mention these in brief:

1. **Passive listening:** acknowledging and encouraging with words and actions [nods..."I see"...]

2. **Parroting:** repeating words of the client to convey that you are listening and to ensure you have the fact right.

3. **Paraphrasing:** saying what the client has stated differently to clarify a point and to bring the matter into focus

4. **Clarification:** this helps confirm that a fact/statement is accurate and encourages the client to elaborate the matter further

5. **Reflection of feeling:** this helps to promote catharsis and express exactly what the client is feeling in the situation

6. **Summarizing:** this helps to bring cohesiveness to everything said in the session especially when several many things have been said in a disconnected and rambling fashion

EXPLORING

In the first instance this is done for gathering information and more importantly in drawing out feelings, thoughts, fears and facilitates insight Some specific techniques include:

1. **Probing - open ended questions**

2. **Pointing out - comment on the style of interaction, bringing client back to the session, give a feed back**
3. Self-disclosure- sharing personal facts, experience etc.

4. Interpreting - promoting insight into what is taking place

5. Confronting - a sophisticated technique to gently point out discrepancies in what has taken place

**TAKING ACTION**

This is to facilitate the client to bring about changes for progress. You can do this in different ways, such as through:

1. Giving information - that is concise, accurate and factual

2. Giving advice - in the form of practical suggestions

3. Setting goals - giving direction, helping plan and getting commitment from client to stick to them

4. Reinforcement: supporting, encouraging to help bring about desirable behaviour in client

5. Directives: Giving specific instruction with an aim to change the specific patterns of interaction or communication

**BASICS OF COMMUNICATION**

What do we understand by COMMUNICATION?

COMMUNICATION is the sum total of messages given/received

We need two people.

It is a two-way process.

Message

Sender A → B Receiver
Messages are sent and received.

It is the transfer of information from one person to another.

It is the transfer of understanding from one person to another.

[Exercise: Irish whispers - Discussion]

Communication is a way of reaching others with

- Ideas, Facts, Thoughts, Feelings, Values

Exercise: List one example of each of the above

GOOD COMMUNICATION INVOLVES

- Attending fully, Listening carefully, Interpreting correctly, Conveying accurately

THE MESSAGE YOU HAVE UNDERSTOOD/RECEIVED

HOW DO WE COMMUNICATE?

There are two modes: verbal and non-verbal

VERBAL: Most of us are familiar with this mode - the use of words. Often there are problems because one word can have many meanings and many interpretations.

[EXERCISE: give words and ask group to add the first coming to mind]

HOW CAN YOU BE SURE OF THE MESSAGE CONTENT?

- Try and get a feed back
- Context can provide the meaning
- Take social cues - where the client is coming from
NON-VERBAL

- **Postures:** the way we stand/sit/walk/sleep/bend...
- **Gestures:** the way we move hands/head/face...
- **Voice quality:** tone, speed, volume...
- **Energy level:** emotions conveyed...

[EXERCISE: given words and sentences to act out - nonverbal]

INDIVIDUAL COUNSELLING

WHOM DO WE COUNSEL?

Individuals......Couples........Families........Groups

THE OLD CONCEPT

- There was a counsellor
- There was a counselee/client
- There was a problem

The counsellor helped the client to solve the problem. Counsellor helped the client to help himself/herself to solve the problem

This was done through social diagnosis.

This was made on the basis of clients past life and present situation.

THE MODERN CONCEPT

- We still have the counsellor
- We still have the counselee/client
- We still have the problem
BUT - Today we do not

- Help the clients to find solutions.
- Give advice to solve their problems.

What we do today is

**FACILITATE THE PROCESS**

This will be an on-going process

The less you interrupt/intervene, the better the facilitation

The client is under stress. He has a problem

Listen to the client. Allow him to ventilate

Avoid WHY questions. They can sound threatening.

WHAT and HOW questions are more proactive.

There are times when you say almost nothing, BUT

The client will say “thank you so much. I feel better already!”

A very common question is “what shall I do?”

Your response in general should be “what do you think you should do?”

The way you respond should take the session forward.

Give something positive for the feel good factor

Help with words, sounds and gestures to take the session further

**EMPOWER THE CLIENTS**

Make the client feels good about himself?

Say something encouraging, but true

In the counselling process check out his plans/needs

As far as possible mirror the situation for client
TAKE THE HERE AND NOW

We work with the situation as it is today

No need to dig out old facts and justify current predicament

This is done in psychoanalysis, but we don't need it

What was then is not valid for today

WORK ON THE STRENGTHS OF THE CLIENTS

All of us have strengths and weaknesses

Find out the strengths of the client

Let him use it to take a step/decision for himself

Help him build it further to take control of his life

WORK THROUGH THEIR FEELING, THEIR EMOTIONS

It is because of the way they are feeling that they come to you.

Use these feelings to help the client.

It will make him feel you are with him and understand.

Do not negate the way a client is feeling, you will lose out.

BELIEVE THAT ALL OF US HAVE WITHIN OURSELVES THE POTENTIAL TO HELP OURSELVES

Through these processes you will be able to bring the best out of your client.

His self worth will go up,

He will feel good about himself,

He will gain confidence and
Gradually begin to take charge of his life.

You have to groom him in this manner.

THIS ENABLES THEM TO

- Resolve conflicts and Solve problems
- Deal with situations

If you feel the need to have

A DEFINITION OF COUNSELLING

You could use a working definition and say

"COUNSELLING is a process of helping individuals for achieving adjustment to become Self-sufficient,
Self-dependent and Self-directed.

COMMUNICATION

Communication is the process of sending and receiving messages, either verbally or non-verbally, between people. As this is a dynamic process, it will affect the relations that exist among people who are communicating with each other.

In a skills-based approach, communication skills are required and demonstrated in listening, active listening, reflective listening, assertion, negotiation, persuasion, providing and receiving feedback, self-disclosure, conflict resolution,
written and other means of non-verbal communication, empathy building and questioning.

Effective communication is a fundamental skill required for developing informed and responsible behaviour in relation to drug use and positive participation in work place, social groups, school life and the general community. Effective communication skills enhance personal relationships and self-esteem whilst ineffective communication skills can result in personal and professional dissatisfaction, loneliness, conflict and estrangement from peers in social, family, school and work settings.

An individual may use alcohol or drugs as a means of coping with social situations. Drug use and other unsafe behaviour stems from an inability to relate to peers, colleagues and family members in a range of social settings. A person may get into the habit because of his inability to express individual ideas, interests and values and to resist unhealthy group and social pressures. Effective communication skills can, therefore, provide people with confidence to relate to other people and situations without the use of drugs. Individual and group relationships can be enhanced through effective communication. If an individual can openly discuss drug issues with a colleague, parent, peer or teacher, the person will become aware of the range of ideas and values relating to these issues, thus assisting them to make informed decisions about their own drug use.

A person with ineffective communication skills will also, possess a diminished level of self-esteem and increased dependence on others to make decisions and resolve problems for them. This can severely impair their ability to cope with drug and other health issues.
Communication starts with listening to what is said and what is not said, the verbal and nonverbal, explicit and implicit messages.

- Communication may be one-way or two-way: Two-way communication means that one is talking, the other is listening. One-way communication means one is talking the other is unconcerned. We would encourage two-way communication in this training programme.

- Talking "up" to or talking "down" to or horizontal and equal respectful communication. Please respect the other participant by talking to the other person as an equal.

**Barriers to effective conversation-1**

*Judging*

Criticizing - e.g., You never understand what I have been telling you.

Name calling - e.g., You are short tempered.

Diagnosing - e.g., Obviously you are not interested to work at this

Praising to manipulate a person

- e.g., You are a kind person. Can you do this for me?

**Barriers to effective conversation - 2**

*Sending solutions*

Ordering : You will come home at 2 o'clock

Threatening : If you do not listen to me I will..

Moralizing : You should do this
Excessive questioning : When did you leave home?

Where did you go?

How long were you out?

Who else was with you?

**Barriers to effective conversation - 3**

Advising - I would tell you to do these instead of

Diverting - Where did you go for your holiday?

Logical argument - The only way to please your boss is to work harder (the emphasis on facts and feelings are avoided).

Reassuring - We will solve the problem (making the person feel better but not dealing with the problem).

Avoiding others' concerns

**Understanding Non-verbal Communication**

- In any conversation between two persons, the verbal components are responsible for less than 35 percent of the message while non-verbal components make up more than 65 percent.

- Non-verbal communication communicates feelings, likings and preferences.

- Non-verbal communication is ambiguous. For example, anger can be expressed by a lot of movement and shaking or by complete stillness. Blushing may convey anger, embarrassment, nervousness or pleasure.
• If the non-verbal actions contradict the verbal message, it will result in confusion. For example, telling someone you trust him or her but at the same time not looking in the face.

• When communicating liking and acceptance, these non-verbal actions are congruent with the message:

   Maintaining eye contact.

   Keeping an upright posture.

   Standing close to the person but not invading personal space.

   Having a warm tone of voice and speaking clearly, not whispering or shouting.

**Non-verbal communication can be conveyed through**

• The way we structure the physical environment in which we work and live.

• The way we sit, stand, walk and make eye contact.

• The distance we stand from others.

• Our environment at home, work or school.

• Gestures: sighing, crying, frowning, clowning, smiling, laughing.

• The way we look - hair, face, body.

• The clothes we choose to wear.

• The colors we choose to wear.

• Tone of voice.
Non-verbal Cues

- Body language - through posture, gestures, eye movements, expressions on the face.
- Quality of voice - loudness, softness, sweetness, harshness, etc.
- Touching - Pat, touch, push, etc.
- Personal space – distance among the participants - sitting too close, too far apart, higher/ lower seat - indicative of intimacy or distance.
- Smell - smelling pleasant or reeking of sweat, foul smelling.
- Neatness of looks - Clothes, hairstyles, jewellery.
- Silence - effective at times to convey shock, disapproval, joy, togetherness, discomfort, hurt.

Effective Listening

- Concentrate on what is being said - avoiding thoughts which distract, not attending to the task at hand, but thinking of something else.
- Emotional triggers - some words used or manner of speaking may evoke strong feelings in others.
- Open to suggestions and open minded or sticking to one's own opinion and not listening to point of view of others.
- Attentiveness to what is being said - listening to the meaning of what is being conveyed rather than to the manner, choice of words used by a member.
- Not taking into account what the other person may want to say - jumping to conclusions.
• Asking for clarification when a member does not convey her/his idea accurately, or is ambiguous.

• False presence of having understood when something is not clear. Ask the member to rephrase, or repeat.

• Respecting the member who is expressing her/his views.

**Effective Feedback**

We will be interacting and responding to what is said or done in this programme, and giving feedback to others. Feedback is a verbal or non-verbal communication to a person or group providing them with information as to how their behaviour affects you or the state of your here and now feelings (giving feedback). Feedback is also a reaction by others in terms of their feelings and perceptions, as to how your behaviour is affecting them (receiving feedback). Pre-requisites of effective feedback are:

• Trust

• Caring concern for other's needs

• Acceptance

• Openness

Whether or not your feedback is helpful and accepted by the receiver depends on that person's own philosophy. If a person feels no responsibility for the effect his behaviour has on others or how others feel, then the feedback will have no effect on changing her/his behaviour. The receiver has to first realize that other's reactions ultimately do affect him, before he can accept and use feedback.
Principles of Effective Feedback

Feedback should be constructive. Do think of the needs of the other person and of what will be useful to her/him.

Feedback should be appropriate. This implies:

- Saying it in the right tone, volume and intonation.

- Giving the feedback at the appropriate time. It is most useful immediately after the event concerned, and not in some other situation, and/or in the presence of some other groups of people.

- That the place to give feedback should be carefully considered. Ascertain if the feedback may be given in a one-to-one situation or in front of whom it is given.

- Giving specific examples of what the other person has said or done. Do not make general statements, such as, 'I feel annoyed because you never listen to me.' Unless you can give some specific examples, the receiver may not understand or believe what you are telling her/him.

- Do describe your own feelings and reactions. For example, "I felt upset". The only thing you can be sure of is your own feelings.

Don'ts of giving Feedback

- Do not speak only of your own need to react or score off the other person; that is irresponsible and destructive.

- Feedback is specific to a given behaviour and carefully separates the action from the self. Do not make evaluative statements about the other person's
character. For example, "you are selfish and controlling". The person receiving this will probably react defensively.

- Feedback is not accepted when:

  The other person has made it clear that he does not want it.

  It is judgmental of the other person's actions. For example, "You were wrong to shout at me". Statements like this will only produce a defensive reaction.

- It describes the other person's feelings or motives or intentions. For example, "you wanted to upset me". "You are only guessing".

Some group skills have been detailed above. These are group rules, communication (non-verbal and verbal cues), and effective listening and effective feedback. Some more are stated below:

**Problem Solving**

An effective problem solving procedure is

- Clearly define the problem: find out what appears deeper as different from what appears at the surface.

- Thoroughly explore and understand the causes behind the problem.

- Collect additional information (from elsewhere if needed) and analyze it to understand the problem better.

- Solutions: think or look for them; try to evaluate logically, then try wild ideas which may seem irrelevant. Use creativity and imagination to look for new patterns within the same set of facts. Ask the group to suspend judgment
and criticism for a while and combine each other's ideas or add on improvements. This is called "brainstorming" (lateral thinking).

- Think of all possible options and consequences of each option. Choose the appropriate and viable option or alternative. Collaborative and consensus based resolution is preferable to forcing a choice. Considerable discussion is needed to analyze the various alternative solutions on the basis of constraints and available resources.

- Act on the viable option/solution selected. Implement the solution through a planned set of activities, and evaluate how the problem is solved. Mid-course assessment may be necessary and mid-course corrections may need to be instituted.

**Decision Making**

This may take place in one or more of the following ways:

- **Self-authorized:** Decision made by one who assumes authority. Others find it convenient to accept decision rather than reject it. There is an assumption that decision will be accepted.

- **The plop:** Decision is suggested by one, there is no other response/proposal, and the decision is adopted. Here, the decision is adopted by default.

- **Pairing:** Two persons joining forces make the decision; one proposes an option, the other seconds it, the others keep silent and the decision is adopted.

- **Minority group:** Decision made by a clique and the rest accept it.
• **Majority vote:** Decision depends upon the majority accepting the decision by a show of hands or a ballot.

• **Consensus:** Essentially a minimum consent by all. When asked, "does anyone disagree?" many who do not agree show apparent support, i.e., there is a false consensus. True consensus occurs where everyone has contributed to the discussion, all angles have been considered, and everyone is in full agreement. This is the desired situation, but may not always happen. The next best is to aim at what everyone in the group feels:

They have had the opportunity to put forth their views and influence the decision.

That there was a open discussion.

They are prepared to act on the decision taken.

**Guidelines for Facilitating Adult Learning**

• Address issues related to professional responsibilities.

• Address issues of timely concern - so that what is learned will be used and not forgotten in the distractions of the workplace.

• Balance theoretical and practical components - to establish a framework of understanding along with practical skills.

• Promote thoughtful discussion because trainees will have substantial experience to share and examine.

• Provide practice in solving problems that are similar to actual on-the-job problems.
• Respect and build on, rather than negate trainees' current practices because they may have their own well-developed beliefs, attitudes and behaviours.

• Stimulate creativity, trust, and risk-taking during training, so trainees may feel committed to the work for which they are being trained.

• Stimulate critical thinking, so that trainees may evaluate what they are learning and consider its implications; stimulate their ability to evaluate and analyze.

• There are no rigid formulae for the life-saving and life-restoring work of rehabilitation. Encourage the trainees to be creative and not bound by the limited set of skills that rote training tends to produce. This is of special relevance in the Indian context where cultural mores vary from place to place. Learning to think creatively in response to the dilemmas of real life, as a model for clients to follow, allows the programme to be culture-specific.

• Concentrate on practical guidance, caring encouragement, successful role models, and a peer learning group.

COUNSELLING ISSUES RELATED TO ADDICTION

Counselling is an important aspect of a structured addiction treatment programme. In contrast with other forms of therapy that are group based, counselling sessions offer an opportunity for the client to work on his individual problems on a one to one level and develop a plan that is uniquely structured to meet his specific needs.
Guidelines for counselling sessions with alcohol / drug abusers

Counseling related to three areas are discussed

- Counselling the client in treatment
- Follow-up counseling
- Counselling family members

The counsellor's ability to establish a strong therapeutic relationship based on respect, trust and concern for the client's wellbeing by and large determines the extent to which the client will benefit from the counselling sessions. Based on this relationship, the counsellor helps the client work towards a drug / alcohol free qualitative lifestyle.

Objectives

To help the client

- Accept the disease concept of addiction and recognise the need to maintain total abstinence from all mood changing chemicals.
- Recognise the damage caused by addiction in the major areas of his life, develop a plan to ensure sobriety and prevent relapses.
- Develop a recovery plan with both short and long term goals to improve the quality of his life.

Planning the counselling session

1. **Number of sessions**: As per the Minimum Standards of Care criteria prescribed by the Ministry of Social Justice & Empowerment, Government of India, a
minimum of 8 sessions for the client and 4 sessions for the family members (along with or without the client) need to be held.

2. **Duration**: Each session should last a minimum of 45 minutes and not exceed one hour.

3. **Frequency**: The counsellor needs to ensure that the first counselling session is held as soon as possible - within two working days after the client has completed detoxification. Thereafter, two to three sessions a week are needed. Some clients of course, will need a few more sessions depending on the complexity of their problems.

4. **Structuring**: The counsellor needs to be seen as a caring and a knowledgeable person who can assist him during treatment as well as in the recovery process. Establishing rapport with the client is of prime importance. The first few sessions will focus on this major issue. While history taking does go on during this period, care is taken not to confront or pressurize the client, for this will only make him defensive and complicate recovery.

5. A rough outline of how the sessions can be structured during the treatment programme as well as follow up has been described in the next section. It should of course be remembered that each client is unique and largely the client himself determines the exact order in which the issues will be discussed and the tempo at which the process will move on. For e.g. while some clients may discuss the drinking history in an open and forthright manner in the first session itself, some may prefer to talk about their general life situation and address specific issues related to drinking only later on.
6. **Recording:** The case history form, apart from serving as a record is also a good guide for the counsellor to ensure that all the significant areas have been addressed. The counsellor also needs to record the duration of counselling sessions, the date, main issues to be covered.

**Session 1 - Getting to know the client**

**Tasks involved**

- Reviewing the case file forwarded from the detoxification ward to get to know basic information about the client even before meeting him.
- Introducing oneself to the client and getting to know some basic details about him and the family members.
- Explaining the goals and structure of the treatment programme to help the client understand what is going to happen and what he can hope to gain. He needs to be given information about the general routine followed in the centre and details about the different treatment components. Explaining that
different concepts would be explained in the native language during the lectures is important. The client needs to understand that while lectures provide information about the different aspects, group therapy helps him relate this information at a personal level in a group setting and self-help group meetings help strengthen his confidence by meeting other people who have worked through their addiction. Explaining the group therapy process, the need to focus on the topic, other rules and what he can do to make the most of it and clarifying questions he may have are essential.

The basis of the counselling contract needs to be clarified. The counsellor needs to explain that during counselling sessions he would be able to talk about his past, recognize the challenges he faces in the present and plan for the future- stressing that the counsellor is a guide and not an authority figure who will help him sort out issues with his participation instead of giving out prescriptions that he has to follow. Most clients feel anxious during the first few days and it is important that the counsellor is seen as a friendly person who will help him out if he has any problems. It is important to assure him that whatever is discussed in the counselling session will be kept confidential and that it will be discussed with the doctor or the other counsellors only if necessary, with the intention of providing him help.
The first meeting can be used to get basic information about the client - where he works, people who live with him, a sketchy outline of his drinking history and why he decided to take treatment. The client is permitted to give as much information as he is comfortable with and the counsellor avoids probing questions or confronting statements. The issues can be discussed again later when the client is more comfortable.

It would be a good idea to have the family members participate in this session. Family members are often not forthcoming with information out of fear of making the client angry or due to denial. Stressing that clients and family members should be willing to look at issues honestly and participate in treatment with an open mind helps. Emphasizing the need for family members to participate in the family therapy programme is extremely important.

It is important to end the first session on an optimistic note pointing out that world over thousands have recovered from alcoholism and that it is possible for him also to do so. And also to convene to the client that the treatment center has the necessary expertise to treat addiction.

Session 2: Childhood and adolescence history

Tasks involved

- Most clients feel comfortable talking about the family of origin even at the initial phase, as it is far removed from their addiction period. Collecting this information helps to break the ice and makes the patient comfortable about talking to the counsellor. For the counsellor, the information collected
helps her understand the strong childhood influences that shaped his personality development. While the information may not have direct bearing on his present situation these issues cannot be overlooked.

- Collecting information about his parents, brothers and sisters and other adults like grandparents /other relatives who influenced him in childhood helps one get a good idea of his childhood relationships and the impact that all this had on his self esteem.

- Details about the family history of addiction, psychiatric problems, depression and suicide can also be noted in this session.

- Specific problem situations that he may have encountered and behavior problems can help the counsellor identify childhood trauma, negative personality traits and the extent to which he coped with problems.

**Session 3: Drinking History**

**Tasks involved**

- Collecting information about onset of drinking and drug using behaviour, helps the counsellor reconstruct the phases in which casual / experimental use gradually developed into addiction. The counsellor needs to be able to discuss the progression in a matter of fact manner. Critical comments can increase the tendency of the client to minimize the quantity or frequency of drinking.

- Drawing the attention of the client to the symptoms of addiction like increased tolerance and loss of control is essential. Most clients do not
realize the long duration of abuse and it is up to the counsellor to make him recognize the denial mechanism that prevented him from recognizing the damage and seek help.

- Collecting the details of his medical problems noticed in the recent past as well as the present helps the client recognize damage related to this area. Most clients show lot of concern and anxiety about health during the initial period. While the counsellor needs to help him see this as the impact of addicting he also needs assurance that recovery is possible.

- In the case of injection users, issues like abscesses, sharing practices, incidence of overdose etc. also need to be handled.

- The counsellor needs to be alert for signs of depression, anxiety, paranoia and hallucinations that may not have been reported until now. It is a good idea to conduct a brief mental status examination.

- Getting to know about the medications that client is on and the prognosis is necessary so that the right kind of information can be given to the client and family.

**Session 4: Meeting the Family**

**Tasks involved**

- Collecting a brief history from the wife/parent/ significant other is a must. It gives the counsellor an opportunity to collaborate information provided by the client. Family members often present
information from a very different angle that helps one understand the intensity of damage. The family member's perception of the client's strengths as well as negative traits and denial can help the counsellor make a comprehensive assessment of the situation.

- Collecting information about the present family environment helps the counsellor to understand the positive as well as the negative forces that can influence recovery.

- Some attention needs to be paid to the disfunctional behavior that family members have developed due to the close association with the client. Stressing that the family members should take care of their own needs and make efforts to change their negative behavior also needs to be stressed.

- The counsellor will be able to identify some of the issues that need to be discussed during joint sessions with the spouse or other family members to sort out the major areas of conflict.

**Session 5: Occupational History**

**Tasks involved**

- Helping the client talk about the jobs he has held, the extent to which he enjoyed each and the problems encountered can give the counsellor a good idea of his work life and work ethics of the client.
- The present job situation needs to be explored in detail. The achievements or the lack of it, the relationship with the supervisor as well as subordinates and the probable problems that he may have to face on completion of treatment, needs to be discussed.

- Unemployment or employment below his potential calls for discussion to find ways to remedy it and may warrant a referral. The client may need help to identify suitable avenues of employment and agencies that can provide vocational training.

- The client is actively discouraged from starting a new business or look for jobs that may increase stress or take him away from the supportive environment at home.

- A brief history of his religious and leisure activities can be collected in the session. This will give the counsellor an idea of the ways in which the client will handle his free time, avoid boredom and cope with stress in the future. If his relationships are restricted mostly to alcohol / drug users, helping him recognize the need to change it is important. The counsellor should encourage the client to initiate efforts to strengthen his spirituality and creatively look for ways in which he can have fun.
Session 6: Financial History

Tasks involved

- A detailed discussion on the amount of money he earns, the monthly expenditure, the assets and debts is needed. Asking the client to make a list of his income and loans even before he attends this session may be a good idea.

- Helping the client recognize the amount of money he has spent on alcohol and drug use and the fact that only a percentage of his earnings was provided to the family is important. While it may seem obvious or simple to others, looking at the figures in black and white and seeing this in the light of his drinking can surprise the client.

- Identifying loans that have been taken at a high rate of interest, prioritizing loans that have to be paid back and making decisions about pawned jewellery /property can be quite complicated and needs a lot of patience. Asking the family to pay back his debts to help him make a fresh start is clearly an enabling behavior and the counsellor needs to avoid it.

- Developing a monthly budget plan to restrict expenses, pay back loans and save at least a minimal amount can be a difficult task. It is a good practice to make sure that the family members participate in the session to make sure that a reasonably good budget is developed. The session can increase* the anxiety level of the client. Reassuring the client that with continued abstinence and financial discipline, he can work his way out of this financial problem, can help.
Session 7: Marital History

Tasks involved

- A brief idea about events that read to the marriage and adjustment during the period before addiction set in, an assessment of how the addiction has affected the marriage is important.

- Inviting the client and his spouse to look at their areas of conflict and helping each express their hurt as well as expectations from the other is a growth enhancing exercise that can be very helpful. However, setting a few ground rules for the session is important. Encourage the partners to describe the situation and focus on how they feel instead of accusing the other. Stress that this exercise is for identifying issues and making changes rather than criticizing and offending the other. Ensure that each will listen to the other and avoid interrupting. If there are many issues to handle, one session can be held to prepare the client for the session.

- Asking the partners about the sexual satisfaction and collecting information about sexual problems that may be present can also be part of the session. It
is important to explain that addiction does affect sexual performance and the body needs about 10 months to gradually recover. Explain that continued sobriety and strengthening their interpersonal relationship will go a long way in overcoming the problem. Stress that quick fix measures like medications do not help.

- Discussing about the probable high-risk sexual behavior with the client in the absence of the spouse is a must. The kind of sexual practices, choice of partners and use of condoms needs to be discussed to evaluate risk of HIV and STI. If high-risk behavior is present, the pretest counseling for HIV needs to be made followed by referral for testing. Irrespective of the test results, posttest counseling must be done as soon as the test results are received. It must be remembered that the information cannot be revealed to the spouse as a matter of routine.

- Issues related to parenting and efforts that need to be made to improve relationship with children can also be discussed. Adult children can participate in counseling sessions where family participation is indicated.
Session 8: Identifying relapse situations

Tasks involved

- Helping the client list various steps he needs to take to safeguard sobriety is essential. Stressing the need to take disulfiram / naltraxone and other medications prescribed for co-morbid problems like depression and other chronic problems like diabetes or hypertension is necessary. Client's queries related to this area needs to be addressed clearly and confidently by the counsellor.

- Asking the client about probable situations in which he may experience a craving for alcohol and feelings that he handled usually with alcohol/drugs is important. Conflicts, stress, physical problems, invitations to drink, meeting drinking friends or frustration can often trigger relapses. Helping the client identify triggers and develop ways to cope without alcohol is a must. Clients often sound optimistic and may not be able to identify problem situations. It needs some persuasion to help him identify high risk situations based on the information collected from the client during the previous sessions.

Other sessions

Only the basic number of sessions have been described above. Clients may need more number of sessions. Apart from these, a meeting with the support person and children is often necessary. Referrals to the psychiatrist or other medical health professionals may be needed. In case of clients who seem to have complex problems and those whose progress is not satisfactory, discussion with a peer is called for to ensure that the best is being done for the clients.
Session 9: Discharge

Tasks involved

- The last session can be held with the client as well as the family member.

- This is basically a re-cap session that captures the issues addressed in the previous sessions. Short and long term goals with regard to each of these areas and specific tasks that the client needs to carry out in relation to his health, financial management, occupation, family relationships and leisure activities are listed.

- The counsellor emphasizes the need for continued follow-up, medications and self-help group meetings. Providing clear directions to the client about when and where he can come for follow-up, whom to meet in the absence of the counsellor, addresses of self-help meetings that he can attend are important.

- Accompanying the client to meet the doctor to clarify the medications needed is a good idea.

- Reassuring the client and expressing optimism about his recovery as well as stressing the need for working with the center continuously are important messages that need to be communicated.
FOLLOW UP SESSIONS

The responsibility of the counsellor and the treatment center does not end with discharge. Research shows that longer the client engages in treatment the better the recovery rate. Follow up needs to be seen as continuation of treatment and is an integral part of it.

Follow up is not a session just to check if he is sober or not. Instead it is a time to

- Review progress made in each area - sobriety, work life, finance and family relationship
- Look out for dry drunk symptoms and relapse triggers
- Provide encouragement based on the improvement made and focus on the need to continue to make efforts in the future

There are a few guidelines that counsellors can follow to improve follow up rates

- Seeing the client as soon as possible. If he has to wait awhile, it is necessary to let him know how long it will take. If he is in a hurry, arrangement can be made to meet another counsellor.
- Clients often see follow up sessions as a visit to renew the medications and do not go into details of how they are feeling and how things are proceeding. The counsellor needs to ask leading questions to help the client make a review of what has happened since the previous visit.
- Apart from a recitation of events it is important to draw the client out and help him express his feelings. Clients often have problems in recognizing their progress. For e.g. abstinence for three months, regular attendance at
work, visit by relatives, happiness expressed by spouse or children are small but important gains made. Expressing appreciation and making encouraging statements are important.

- Asking questions related to appetite, sleep, tiredness, concentration and mood state is essential. This can alert one to the possible health problems and side effect of medications. The information has to be collected prior to meeting the doctor and reported in detail. Request for medications should be based on symptoms and facts. Medications are gradually reduced as progress is made and the counsellor needs to be aware of it. Clients with chronic problems like diabetes and blood pressure need to be reminded of the need for regular check ups and medications.

- Reminder about the next visit can be made. Most clients find it uncomfortable to come on a fixed date and time for follow up and the counsellor needs to be flexible. The frequency of the visits needs to be based on the client's situation

- Relapses need to be seen as a part of recovery. Out-patient / in-patient detox and Relapse Prevention Programme need to be offered appropriately. Even when unable to admit the client again for inpatient treatment as requested by the client / family, the counsellor needs to handle the situation without offending or hurting them as they are already in pain.

- Failure to report for follow up calls, for letters, telephone calls or house visits.

- Recording of all follow up visits and efforts made need to be recorded in the follow up card.
ADDRESSING FAMILY ISSUES

During counselling, the family is helped to talk about their life situation openly. Based on this they are helped to:

- Gain insight into the manner in which addiction has affected them.
- Recognize and understand issues related to the problem areas.
- Express their feelings about addiction and come to terms with it.
- Develop a recovery plan to make constructive changes both in terms of support they will extend to the drug-abuser as well as to improve their own lives.

Significant issues

- Families are so concerned about the addict that they do not think of themselves. It takes a lot of patience and persuasion to get them to talk about themselves.

- Family members may be as much in denial as the drug abuser and may be reluctant to honestly face issues. They may blame each other and conflicts that arise within themselves can interfere with recovery. The counsellor needs to get all of them to focus on a common goal of establishing a stable family environment.

- The counsellor needs to maintain a "here and now" focus rather than going too deeply into the past and address the present issues. Even though other issues may be present, the focus of the counselling is on providing a supportive environment for the drug user and reducing the disfunction in the family.
Confidentiality is very important. Whatever each family member says in strict confidence cannot be repeated to others or the addict without their permission. It is to be used for the benefit of the drug abuser and the family.

**Stages of counseling**

- Counselling can be seen as a process that goes through five stages. Let us look at each stage separately

**Stage I: Developing a therapeutic relationship Tasks for the counsellor**

- Demonstrate attitude of concern/ warmth / respect

- Discuss treatment programme and encourage wholehearted participation
  
  Create a non-threatening atmosphere to help discuss issues openly and
  
  Overcome resistance

**Counsellor's method and approach**

- Collect basic information about family members

- Understand the role of each member

- Get to know the attitude of each member towards the drug abuser

- Understand the anxiety / concerns of family and their expectations from treatment

- Get an idea about the damage caused to family

**Benefits**

- Family feels accepted / experiences a sense of relief

- Trusts Counsellor / shows willingness to work on issues
Stage – 2 : - Exploring problem areas

Tasks for counsellor

- Helps the family member talk about problems in detail
- Enables family to share feelings / damage
- Helps to bring unexpressed thoughts / feelings into the open
- Uses probing responses and confrontation if necessary

Counsellor’s method and approach

- Helps members identify co-dependency traits, coping styles / other disfunctional behavior
- Helps family understand different roles to be played that enable the client to continue with abuse
- Gets all members involved / recognize roles in supporting drug abuser’s recovery
- Enables family recognize need for change in themselves

Benefits

- Family members view situation objectively
- Family recognizes its need to change : not focusing on the addict alone

Stage 3 : Setting goals

Tasks for the counsellor

- Prioritizes issues / focuses on important areas
- Brain storms options : alternative ways to solve problems; positive/ negative consequences of options
- Ensures active participation of family members
Counsellor’s method and approach

- Helps members develop a plan: reorganize daily routine; establish better communication

- Enables family to recognize the need to strengthen support systems

- Offers guidance to make recovery plans to reflect values/personality style of members

- Encourages them to understand their roles to encourage the recovering drug abuser, even while focusing on changes in their own life style.

Benefits

- Family develops a recovery plan: short/long-term goals

- Realistic/work plan; specific steps to establish a fulfilling life style

Stage 4: Maintaining changes

Tasks of the counsellor

- After completion of therapy, continues to provide encouragement / support

Issues handled by the counsellor

- Motivates family members to live by recovery plan

- Identifies / helps deal with problems as they arise

- Helps them set higher goals / change recovery plans, if needed

Benefits

- Helps family to work on their recovery in a consistent manner

- Sustains their efforts / motivation to change
Stage 5: Termination

Tasks of the counsellor

- Gradually reduce their dependence on counsellor (closure)
- Motivate further growth and recovery in families

Counsellor’s method and approach

- Increases their support base / encourages independence
- Helps family members recognize their growth and provide encouragement
- Helps them see the need to provide support to client as and when necessary

Benefits

- Helps them function independently
- Learn to use own resources / use of self help groups
RESEARCH METHODOLOGY

Good research generates dependable data being derived by practices that are conducted professionally, than can be used reliably for decision making. Good research is carefully planned, conducted and wise decisions can be made.

Research is an academic activity and as such the term should be used in a technical sense. Research comprises defining redefining problems formulating hypothesis or suggested solutions. Collecting, organising and evaluating data is the main motto of the good research design.

RESEARCH DESIGN

Title of the Topic

“Use and Abuse of Drugs - A Study in Rayalaseema Region of Andhra Pradesh”

Objectives of the Study

1. To describe the socio-economic profile of the drug users

2. To examine the different types of drug use and the extent of their use.

3. To understand the causes for drug use and abuse.

4. To assess the impact on family, relatives, friends and colleagues in the use and abuse of drugs.

5. To explain the effectiveness of the rehabilitation programmes.

6. To explain the effectiveness of counselling in becoming a non-user and continuing a sober life.
Sample Size

The sample size consists of 600 respondents representing four districts of Rayalaseema – Chittoor, Kadapa, Anantapur and Kurnool. It constitutes 376 respondents from Chittoor, 151 from Kadapa, 12 from Anantapur and 61 from Kurnool. All these respondents are clients of De-addiction Centre run by People’s Action for Social Service (PASS) located in Tirupati of Chittoor District, thus the sample is a self-selected and convenience sample.

Tools of Data Collection

A structured interview schedule has been prepared in local language and administrated for collection of data from respondents. Apart from using interview schedule, participant and non-participant observations were also used in the collection of the data pertaining to the sample. The age group of the respondents ranges from 30 to 40 years. All the respondents are males.

The secondary data was also collected by consulting the published journals, text books, manuals from Regional Resource Training Centre (RRTC), TTK Hospital Chennai, De-Addiction Centre, National Institute of Mental Health and Neuro Sciences (NIMHANS) Bangalore, Ministry of Social Justice and Empowerment, Government of India (MSJ&E) New Delhi, United Nations Office on Drugs and Crime, Regional Office for South Asia (UNODC, ROSA) New Delhi, on Treatment and Counselling process for the drug addicts.

The data has been collected from January 2011 to July 2013.
FIELD AREA

The field area comprises of four districts of Rayalaseema Region of Andhra Pradesh namely Chittoor, Kadapa, Anantapur and Kurnool.

Rayalaseema (Rayalasima) is a geographic region in the state of Andhra Pradesh in India. It includes the southern districts of Anantapur, Chittoor, Kadapa and Kurnool. With an area of 67.526 km² (42.00% of state area), Rayalaseema is larger than Kerala, Punjab, Himachal Pradesh and nine other states in India. It has a population of 15,184,908 (2011 census), which is 30.03% of the state population.
Rayalaseema borders the state of Tamil Nadu to the south, Karnataka to the west, Telangana to the north and Coastal Andhra region of Andhra Pradesh to the east. The region contributes 52 assembly segments to Andhra Pradesh state legislature and 8 parliamentary constituencies to Indian parliament. These Telugu-speaking districts were part of the Madras Presidency until 1953, when Telugu-speaking districts of the Presidency were carved out to form Andhra State. From 1953 to 1956, the region was part of Andhra State. In 1956, the Telangana region was merged with Andhra State to form Andhra Pradesh State. Earlier, Bellary district was part of Rayalaseema. With the formation of states based on languages, Bellary was merged to Karnataka. The city of Bellary, which has large numbers of both Kannada and Telugu speakers, was included in Mysore after protracted debate and controversy.

Rayalaseema was ruled by Sri Krishna Devaraya. Rayalaseema was the original home of the Eastern Chalukyas, which gradually extended their sway over Karnataka under pressure from the Cholakings. Although Rayalaseema is a small region compared to the rest of Telugu-speaking areas, its contribution to Telugu, Kannada, Tamil, and Urdu arts, culture and literature is immense.

Before and around the period of Chalukya, i.e., 7CE period, it is also called "Hiranyakarastrasu". Only during and after the Vijayanagara era is it called Rayalaseema.

During the British era, the Nizam of Hyderabad ceded this area to the British, and is also called Ceded Districts. After Independence, it was renamed as Rayalaseemaas 'seema' was an administrative unit of the Vijayanagara Empire similar to today's districts,
The name RAYALASEMA was widely accepted and well received by the intellectuals and people at large. When Andhra Pradesh leaders started a ‘separate Andhra’ movement to secede from Madras State, the Rayalaseema leaders did not support it initially mainly due to the doubts about the development of this area of united with Andhra after the separation. To clarify the doubts of the Rayalaseema people the ‘Sribagh Pact’ was made on 16 November 1937. The signatories of Sri Baghpact were K. Koti Reddy, KalluriSubbarao, L. Subbarami Reddy, BhogarajuPattabhiSetharamayya, KondaVenkatappayya, PappriRamacharyulu, R. Venkatappa Naidu, H. Seetharama Reddy.

The main points of the fact were:

- Whenever an Andhra Pradesh State is formed, the capital city would be located in Rayalaseema Region.

- The High Court will be located in Andhra Region.

However, not with standing with the fact, the present - day A.P. Government decided to locate both the capital city and High Court in Andhra Region, a move which clearly violates the Sribagh Pact.

Sources of Economy

Rayalaseema is rich in minerals. Asbestos, Barytes, Chinaclay, Calcite, Dolomite, Diamonds, Green Quartz, Iron Ore, Lime Stone, Silica sand and what not. Even the rarest metal Purallin, lighter than cotton and sturdier than steel is found in Mangampet of Kadapa district. It is useful in curing cancer, AIDS and as bullet-proof material.
Rayalaseema also has rich forest wealth like the rare Red sandal wood which is highly economical and main revenue source for the state and other forest sources include non-timber resources, medicinal plants etc. The region has the TTD board, the richest religious board in the country has deposits worth thousands of crores of rupees. The region has close proximity to sea ports like Krishnapatnam port. Dugarajapatnam port, both are located within the parliamentary limits of Rayalaseema region. Especially the Krishnapatnam port is well on its way in becoming the largest automated pot for exports and imports in South Asia.

Culture

Literature

Telugu culture reached its zenith during the Vijayanagararuls under Sri Krishnadevaraya. Amongst AshtaDiggajas, AllasaniPeddana, Dhoorjati, Nandi Timmana, MaadayyagariMallanaandAyyalaraju Rama Bhadrudu are from this region.

Poets like Vemana, Sri PotuluriVirabrahmendra Swami from Kadapa District played a great role in educating the common people through their literary works. It is also claimed by some experts that Pothana, who penned Andhra Mahabhagavatham, was actually born at Ontimitta village of Kadapa District.
List of districts in RAYALASEEMA

<table>
<thead>
<tr>
<th>S.No.</th>
<th>District</th>
<th>Head Quarters</th>
<th>Population (Census 2011)</th>
<th>Sex Ratio (per 1000)</th>
<th>Average Literacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Anantapur</td>
<td>Anantapur</td>
<td>4,081,148</td>
<td>977</td>
<td>63.57%</td>
</tr>
<tr>
<td>2</td>
<td>Chittoor</td>
<td>Chittoor</td>
<td>4,174,064</td>
<td>997</td>
<td>71.53%</td>
</tr>
<tr>
<td>3</td>
<td>Kurnool</td>
<td>Kurnool</td>
<td>4,053,463</td>
<td>988</td>
<td>59.97%</td>
</tr>
<tr>
<td>4</td>
<td>YSR (Kadapa)</td>
<td>Kadapa</td>
<td>2,882,469</td>
<td>985</td>
<td>67.30%</td>
</tr>
</tbody>
</table>

CHAPTERISATION

The thesis has been organized into five chapters

The **First Chapter** covers Introduction, types of drugs and Research Methodology.

The **Second Chapter** deals with Review of Literature.

The **Third Chapter** deals with Socio Economic Profile of the Respondents.

The **Fourth Chapter** deals with Data Analysis and Interpretation and Case studies.

The **Fifth Chapter** describes the Findings, Conclusions and Suggestions for further research and action.